# Appendix C
# Narrative Reports from Interviews

Narrative Reports are listed alphabetically by last name.

## Gary Adams
### Chief, Oklahoma Highway Patrol and Mike Grimes, Captain

The Captain and the Chief recall going directly to the scene but in different roles. Captain Grimes reported to the scene to set up a command post for the Highway Patrol, while Chief Adams began assisting the injured. Both men recall massive difficulty with communications, both internally among troopers and externally between agencies.

The Highway Patrol assisted with the crime scene investigation and helped the Oklahoma City Police Department (OCPD) in securing the perimeter. Some troopers assisted in the early rescue effort before the bomb scare at 10:30 a.m. Approximately 600 troopers rotated in to aid in securing the perimeter. Some troopers were assigned to help with the Family Assistance Center designed to establish security and escort families to their cars each day.

Lessons Learned:

Issue #1: Communication

Discussion: During the first hours of the incident, cell phones were blocked and telephone lines were down. Communications within the Highway Patrol were limited and communications between agencies was non-existent. It was difficult to organize and the lack of communications made the situation worse.

Recommendation: Communications are critical. There is a need to account for troopers who have responded to the scene and are inside the building helping the injured. Today, Oklahoma City has established priority cell phone usage so that first responders can communicate via cell phone; however, communication efforts between agencies are still a topic of discussion.

Discussion: It is important to keep daily liaison contact. Daily briefings are important to ensure coordination.

Recommendation: Ensure your plan provides for daily briefings between command posts and everyone has the same focus and mission.

Issue #2: Spontaneous Volunteers

Discussion: Thousands of volunteers responded to the scene to help. This created a huge problem. First responders who were dealing with the recovery effort were suddenly in the position of trying to organize volunteers. Volunteers needed to be properly identified and assigned a place to work. No one was prepared to handle so many volunteers.

Recommendation: Make certain the disaster plan calls for a process to organize volunteers.

Issue #3: Identification Badges

Discussion: Several imposters tried to get into the crime scene; some of them were media personnel. The ID process was a major issue due to lack of controls and systems in place. No one had been designated to issue ID's and the system was hit and miss.

Recommendation: Communicate with other agencies during disaster preparedness planning and identify a system and agency to operate the system. ID badges should be unified and eliminate confusion.

Issue #4: Established Relationships

Discussion: Initially there were some turf issues but the local responders maintained control and other agencies at the state and national level became assisting agencies.

Recommendation: Establish relationships between agencies at every level, determine jurisdictions and determine how they will work together.

Issue #5: Shift Rotations

Discussion: Rotating troopers in for 3 day/12-hour shifts was a good decision. Anyone wanting to help was given an opportunity, and this helped morale. At the same time, it was important to continue focusing on statewide patrol

and maintaining day-to-day business. Trooper Charlie Hanger was the trooper responsible for arresting Timothy McVeigh. Had he not been on his routine beat, catching McVeigh might not have been as successful.

Recommendation: Designate a shift rotation and stick to it.

Issue #6: Stress Debriefing

Discussion: The troopers were briefed prior to coming on shifts and then debriefed before they returned to their home assignments at the end of their 3-day shift.

Recommendation: Stress debriefing is necessary and important to the process.

Issue #7: Multiple Agencies

Discussion: FEMA was not equipped or prepared to handle the crime scene investigation. This event proved to be a lesson for them. It was frustrating to work with them at first, but once everyone settled into their roles and respected each other's tasks, everyone worked together.

Recommendation: When possible, practice disaster plans with other agencies at other levels. Get to know the key players and work through situations before incidents occur.

Issue #8: Media

Discussion: The media wanted to do their job and report, but it was important to keep them back and safe from further situations. In the first hours, it was difficult to isolate the media but once a perimeter was established, it was easier to control the crowds and the reporters.

Recommendation: Properly identify a way to separate and isolate the media in a disaster plan so that they can be a resource instead of a hindrance.

## Dick Anderson

### Executive Director, Associated General Contractors

On April 19, 1995, Dick Anderson was at his office approximately seven blocks from the Murrah Building. He was director of Associated General Contractors (AGC), a statewide construction trade association composed of all the major industrial/commercial general contractors, sub/specialty contractors, suppliers and other industry professionals. By virtue of his position, he had the opportunity to be personally acquainted with a majority of the construction industry and its companies throughout the state. His association is a primary component of the construction industry directing efforts toward business development, legislative affairs, safety, and management and trade education.

Two contractors, Flintco and Boldt Construction, called his office and notified Dick they were going to take equipment to the site. The AGC office determined their role should be to act as a clearinghouse of resources for the search and recovery efforts. Calls started coming in from all over the state and the nation. The AGC offices immediately began compiling a manual database of:

- Company names and contact personnel
- Supplies on hand
- Delivery access
- Appropriate phone numbers

Anderson remembers that there were enough materials and supplies donated to build an entire city, and no one charged a dime. His offices helped orchestrate the donations of lights, generators, materials, equipment and labor. At the end of the first day, the workers needed boots, gloves, ponchos, kneepads and flashlights. One vendor brought a 40 ft. truck filled with enough of those supplies for every worker. The construction efforts of the search and rescue were coordinated with four main construction companies:

- Midwest Wrecking - Hauling debris
- Allied Steel - Cranes and heavy equipment
- Flintco - Shoring
- Boldt - Site Construction

These four contractors coordinated with the incident commander and FEMA each day to discuss the tasks and how they were going to be handled. The construction workers were responsible for constructing the tunnels that the firefighters used to get to the victims. There were approximately 200 workers who volunteered their time to the 17-day project.

Lessons Learned:

Issue #1: Resources and Contacts

Discussion: For days after the bombing, staff compiled lists of resources and contacts for the recovery effort.

Recommendation: Have an established database of the construction and materials resources available in your community prior to an event.

Issue #2: Established Relationships

Discussion: AGC had relationships established with all of the local construction companies. Because those relationships were in place, it was quick and easy to coordinate equipment. However, there had not been established relationships between incident command and the AGC offices.

Recommendation: AGC, or a like organization, is a vital resource to a city's disaster plan. At the least, the incident commander should have the phone number and contact name of someone to coordinate all the materials, supplies, and equipment. The AGC of America has compiled a book called "Fast Aid" which serves as a resource manual with blanks to fill in local resources for the different trade disciplines. This is important information to map out ahead of time.

Issue #3: Stress Debriefing

Discussion: Most construction workers are "macho" and don't act as though they need to talk about what they experienced or what they saw, but many of them saw, smelled and experienced horrific things. They should have been given an option to talk through those events with someone or at least been given a contact if they wanted to talk with someone at a later date.

Recommendation: The construction workers should be debriefed. To Dick Anderson's knowledge, none were.

Issue #4: Planning and Preparedness

Discussion: The AGC offices did not have a disaster plan and to date, still do not. They maintain that they are reactive. They believe that because no two events are alike, planning would most likely not make much difference. The response to a tornado and the response to the Federal Building were very different. However, had the AGC office taken a proactive role in planning and preparedness, the incident command and the rescuers could have streamlined efforts early in the recovery process. Established relationships among local construction companies and the fire department paved the way for an easier process, but planning needs to facilitate relationships among new players as they are added to the mix for potential future disasters.

Recommendation: Implement a plan that includes the local AGC offices working with the local responders. Ensure that lists of resources are current and updated prior to an event.

Issue #5: Provide Appropriate and Adequate Recognition

Discussion: Some construction workers at the Murrah Building felt they were never publicly recognized for their efforts. The construction workers paved the way for the firefighters and many gave their time, effort and money and asked for nothing in return.

Recommendation: Remember to recognize individuals for their participation in a timely and appropriate fashion.

## Albert Ashwood

### Director, State Department of Civil Emergency Management

At the time of the April 1995 bombing, Ashwood was the Recovery Manager for the State Department of Civil Emergency Management. Ashwood recalls that planning had never involved a terrorist activity or a disaster involving so many people and so many agencies. At the time of the explosion, he was in his office in the Emergency Operations Center housed in an underground tunnel connecting the state office complexes. Built during the cold war, nothing could be heard or felt. His director grabbed a couple of two-way radios and assigned Ashwood to the scene to report back.

At the scene he tried to first find the command post of the fire department. Once he found the incident commander, he offered any and all state resources needed. The number of injured people and the amount of gray ash in the air amazed him. After moving the command post several times throughout the day, headquarters were finally established at the Southwestern Bell building approximately three blocks away.

Lessons Learned:

Issue #1: Coordination Between Multiple Agencies

Discussion: This disaster took place in a federal building, in the state of Oklahoma, in Oklahoma City. There was no jurisdictional plan for this type of event. Key individuals from the local level were not aware of the state's Integrated Emergency Management System (IEMS). Terminology for each agency was not unified, which caused further frustration and difficulty. Additionally, the state's disaster planning had not addressed terrorism.

Recommendation: The relationships among different levels of players are very important to establish before an event. Planning and training should include dialogue between city, state, and federal agencies. Players should meet and establish relationships as part of training. Effective coordination should take place prior to meeting for the first time on the scene of an incident.

When possible, jurisdiction should be carefully delineated to avoid confusion during a disaster. The incident command post is as important as the multi-agency communications center. Everyone needs to communicate and coordinate to maximize efficiency at every level.

Issue #2: Plan and Practice

Discussion: Prior to this event, Oklahoma had only planned for natural disasters. Terrorism was a concept that "larger cities" had to deal with.

Recommendation: All planning and preparation can and will be unique. Never assume it can't happen to you. The importance of a well written, well thought out and well practiced plan should be a first priority.

Issue #3: Dual Missions - Crime Scene vs. Recovery

Discussion: There were two completely separate missions. The fire department was charged with tending to the recovery efforts. The FBI and police were charged with a major crime scene. Both missions were very important in managing effectively and efficiently.

Recommendation: From day one it is important for the key players to establish and prioritize the order of business: 1) Save lives, maintain safety, find bodies. 2) Secure the crime scene and protect the evidence. This was easily accomplished due to the established relationships between the local chiefs. When Weldon Kennedy, FBI, came on site the second morning he galvanized the order and further defined that even though this was a crime scene, it was a search and recovery effort first. Weldon Kennedy helped set the tone for any potential turf issues.

Issue #4: Media

Discussion: During the first hours, the media personnel were on the scene. They would hear someone say they needed something and then broadcast to the public to bring whatever was needed to the site. This created chaos and duplication. Many times, what they would hear was simply a request for an item already available at the scene. Additionally, public information officers from various agencies began hosting media conferences at different locations. The effort to coordinate information between each agency was difficult.

Recommendation: Prior to an event, establish a location for the media far enough away to contain them and close enough to utilize them as an ally. Local and state agencies need to establish joint information systems and coordinate media efforts. Public information officers from each agency need to be trained with the same protocol and terminology whenever possible. When the incident command is unified, the representatives from each entity involved with media should be unified as well. This secures effective coordination of information between all agencies at all levels.

Issue #5: Tracking Injured

Discussion: It was very difficult to track all the injured at all the various hospitals. Family members were traveling from hospital to hospital searching for their loved ones. It was chaotic and disorganized.

Recommendation: Establish a relationship between the hospitals and determine an organized process to track the injured and report the information in a unified fashion for the families.

Issue #6: Donations

Discussion: Thousands of items, ranging from search and rescue equipment to food, supplies and clothing, appeared in Oklahoma City from all over the world. This created issues with storing and managing these resources. There was no appropriate method to check them in and secure their safety or properly account for them. Donations were arriving and there was no appropriate way to identify when the requested resource arrived and where it was needed. Further, several different agencies would make requests for the same need.

Recommendations: A state donations management plan should be developed and all local, state, and federal agencies should incorporate this plan into their individual plans so that donations can be properly resourced, accounted for and managed.

Issue #7: Defined Roles

Discussion: It is human impulse to want to be in the know, to want to take charge and to want to try to do it all.

Recommendation: The fact is, you cannot add anything to areas that are not your concern.

During a disaster, focus on your role and stick to it. You are more productive and beneficial to the outcome by knowing your role and doing your job to the best of your ability. Have faith that your role is important to the final outcome. Along the same lines, recognize the importance of working together. When decisions are made, support those decisions and resist the urge to second-guess them. Establish who is in charge before an event. In this event, it was a federal building, but the local departments were in control because they were the first responders.

Issue #8: Human Element

Discussion: The focus was always to support those who lost so much. Take care of the victims and their families. Be compassionate to their needs. When someone loses someone, all they want is information.

Recommendation: Planning should always include the human element. Prepare for mass casualties and the repercussions from them. Families are a key component to the process. When they are well cared for, an entire operation can run smoothly.

## Ray Blakeney

### Executive Administrator, State of Oklahoma Medical Examiners Office

On April 19, 1995, the medical examiner was about 2 hours outside of Oklahoma City on his way to Little Rock, Arkansas when he learned about the incident. He recalls that being a blessing in disguise because it gave him a few hours to communicate by phone, think about his disaster plan and start putting things in place to handle the large number of lives potentially lost. Fortunately, he had spent the previous four years planning and becoming educated for a disaster such as this one.

Blakeney knew that a Family Assistance Center was critical to the process. He realized quickly that his role was to take care of the families, coordinate the recovery effort with the fire department and FBI, and identify bodies.

One of his first actions was to call Southwestern Bell to install 20 hard line phones for communication. He then lined up refrigeration trucks for preservation of bodies and started seeking a place for a Family Assistance Center. A final immediate task was to secure body bags.

By 12:30 p.m. the First Christian Church was established as the location for the Family Assistance Center. It was centrally located, provided adequate parking and with only two entrances, it was easy to secure. By 3:30 p.m. it was fully operational thanks to the help of the Red Cross, Salvation Army and the Funeral Directors Association. The Medical Examiner's office provided personnel and advertising with the media to notify family members where to come. Nearly 1,400 family members utilized the FAC. The FAC was open from 7 a.m. to 10:00 p.m. each day for 17 consecutive days.

Lessons Learned:

Issue #1: Established Roles

Discussion: During the Oklahoma City bombing, the Family Assistance Center was initially set up in two different places by two different agencies. Neither realized the other was working on establishing the FAC. Both agencies finally learned that duplication was occurring in part due to the media. This caused major confusion for family members who were hearing conflicting reports of where to go.

Recommendation: Decide before an event who is responsible for taking care of the Family Assistance Center. Determine whether the Medical Examiner's Office or the Red Cross are responsible for setting it up. Establish the relationships and the roles of each prior to an event and assign roles and responsibilities.

Discussion: The major players in Oklahoma City had been to Maryland for disaster training months prior to April 1995. This allowed most of the players to work together, establish relationships and build a trust factor. Because many of the players had practiced together in drills, the steps and actions taken in April became second nature and most knew their counterparts were taking care of their part so they could focus on other issues at hand.

Recommendation: The relationships with the key players are critical to the success of the recovery. Know the key players in the process ahead of time and practice roles.

Issue #2: Planning and Preparedness

Discussion: During the Oklahoma City event, the ME's office used hospital personnel to assist with x-ray, forensics, dentistry, etc. A D-Mort Team was also activated through the Department of Health.

Recommendation: Have a disaster plan. Be flexible with the plan and the people in the plan and use common sense. Know you will make mistakes. Reference your plan and try to be organized before a disaster occurs.

Issue #3: Communications

Discussion: At the Family Assistance Center people wanted answers and they wanted someone to hang on to for every piece of information possible. There were no provisions in the plan to regularly meet with family members. It became obvious the first night when over 1,400 people were standing silent in the room waiting for information, someone needed to report to them. The medical examiner became the person they learned to trust to give them the final word each day.

Recommendation: Identify the most appropriate person to report to the families. Make certain it is someone who is sensitive but truthful, shows up when they say they will, and does what they say they are going to do. Make sure the spokesperson is compassionate and has good common sense.

Discussion: Because of the complexity of the recovery effort, it was important to maintain constant communication with other key players and their tasks. To avoid overlap, confusion, and misreporting of numbers, etc., it was important to have daily briefings where notes could be compared and unified decisions could be made.

Recommendation: Establish routine meetings daily with the key players such as fire, police, and FBI to update each other and enforce a unified command.

Issue #4: The Human Element

Discussion: Each day in the Family Assistance Center the medical examiner would meet with families to answer questions. The questions were specific and hard regarding loved ones and the details of their condition. It became apparent that the questions needed to be answered to avoid mass anger and upheaval. Emotions were high and compassion and common sense, which hadn't been written in the plan, were the prevailing forces.

Recommendation: Always put the family first. Give them good, reliable, factual information in a sensitive fashion.You cannot shelter them from the bad information. If they ask the tough questions, give them the answers.

Discussion: One of the designated resources for helping talk with family members in Oklahoma City was the Funeral Director's Association who were identified by their name tags. In retrospect, they should not have been allowed them to wear their own name badges. They needed to be identified as medical examiner personnel instead of funeral directors for the family members who were not ready to acknowledge their loved one might not have survived.

Recommendation: Use a common sense approach when setting up resources for family members. Think through each task and understand up front what each consequence may be during a highly emotional and chaotic disaster.

Issue #5: Resources and Staff

Discussion: Oklahoma City brought in USAR Teams, Chief Ray Downey from New York and other experts to assist with the recovery efforts.

Recommendation: Know your limits and don't be afraid to ask for help. Have an updated resource list of where you can find people and how to contact them. When possible, establish rapport with them prior to an event. Don't be afraid to ask for help.

Discussion: The Medical Examiner's Office brought in three mental health professionals the first day. It was important to take care of the staff physically. Staff was fed, provided good working conditions and massage therapists if necessary. This provided a more balanced working environment and provided the necessary resources for the staff to reenergize and handle the task at hand.

Recommendation: Bring in the necessary and appropriate resources to take care of your staff. Include mental health professionals and provide long-term mental health care for your staff.

Issue #6: Media

Discussion: The media became the single source of disseminating information to families regarding the Family Assistance Center. They were also the source to eventually recognize there were two separate Centers being established and, therefore, causing more confusion for families. In the early hours of the Family Assistance Center organization, some media personnel were deluging family members with inappropriate questions and causing more chaos to the process.

Recommendation: Use your media to your advantage. Use them to disseminate information to families early in a disaster, such as the location of the Family Assistance Center. But then be sure to restrict them. Never report to them before you have told the families FIRST. You have to be available to your media so they act responsibly.

## Rick Buchanan

### Press Secretary to Governor Keating

The morning of April 19, 1995 was an "incredible morning" for Rick Buchanan. As the Governor's press secretary, he had just settled into his office after attending the Mayor's Annual Metro Prayer Breakfast along with 1,200 community, business and government leaders. From his office in the State Capitol, located 2 ½ miles NE of downtown, he felt nothing at the time of the bombing. He first learned of the bombing from his wife who frantically called him from her office.

Upon learning what had happened, he called the Governor. The Governor was scheduled to fly to Ft. Worth, TX at 10:00 a.m. that morning for the BRAC hearings, so Rick met with his boss, Dan Mahoney, and other office personnel to cancel the Governor's flight.

He then stayed in his office to field media questions and tend to business, while the Governor and the Civil Emergency Management Director and others went to the "bunker" (the incident command post). Immediately he was screening calls from the media and the only thing he could tell them was what he was already hearing and seeing on TV. They weren't even certain they were secure and safe in their own offices. The first priority was to take care of local media, then regional, then national.

Lessons Learned:

Issue #1: Communication

Discussion: The State's Emergency Operations Center was built during the cold war and does not allow pagers and cell phones to penetrate the building. Therefore, there was no way for Buchanan to communicate with the Governor while the Governor was in the SEOC. Because the Governor was in the SEOC for 6 hours, Buchanan was unable to communicate and plan the next steps with the Governor and staff.

Recommendation: Appropriate lines of communication need to be in place, with an alternative backup plan. Ensure the disaster plan allows for proper communications between staff and the Governor during the first hours of a disaster.

Issue #2: Media

Discussion: During the first day of the incident, the only information available was information being broadcast by reporters. Therefore, Buchanan could only reiterate what the public was already hearing. Because communication lines were down all over the city, there was no way to know what was happening at ground zero and what the plan of action was.

Recommendation: The media expects comments from top public officials and without adequate information there is not a lot of factual information to report. Give the best and most accurate information to the media as soon as possible. Consider comments carefully before releasing.

Discussion: Several public officials tried to use the daily FBI press conferences as a grandstand. This is not appropriate and hinders progress.

Recommendation: Keep a tight perimeter on major press conferences. Only individuals directly involved should attend.

Issue #3: Stress Debriefing

Discussion: The Governor's staff was offered stress debriefing, but Buchanan declined. He felt he should have been forced to talk through his experiences and if he had been, his life would be different now.

Recommendation: Stress debriefing should be mandatory for EVERYONE.

Issue #4: Responsibility to the Public

Discussion: The public NEEDS a leader they can relate to in the first hours of a disaster. They need a leader to tell them everything will be okay and that things are being handled. Governor Keating visited the site, the Family Assistance Center, hospitals, etc. and constantly asked victims, families, and volunteers, "What do you need?" That was how they were able to plan the next steps based on what each group needed.

Recommendation: Put the right person out in front of the media as soon as you can. Have a plan in place to have a leader identified and if not that person, a backup. Provide access to your leader.

Discussion: During the aftermath of a disaster, it is easy to get caught up in the sudden exposure from all over the world. When your State becomes the attention of public figures from around the world, it is easy to acquire "star fever" and forget personal roles with regard to the big picture.

Recommendation: Never lose sight of what's happening around you. The Rescue effort should be the FIRST priority. Don't forget to hug your family each day.

## Joevan Bullard

### Assistant City Manager, Oklahoma City

Joevan's initial reaction when he heard the explosion was that the air conditioner had fallen through the roof at City Hall. Once he saw the plume of gray smoke and paper and debris flying through the air, he thought a gas line had exploded. Within the first twenty minutes following the initial explosion, he contacted the City Manager and then went to the command post at the site.

He and the city manager met with the fire chief, police chief and the mayor and began coordinating with public works to set up barricades, radios, perimeter security, and any other assistance needed by incident command. He also helped secure employees from Oklahoma Natural Gas and Oklahoma Gas and Electric to shut off power and gas to the building. Once the command post was established and basic needs were met for incident command, Joevan was concerned with a water line flooding the building. Traffic was so congested that the water utility employees couldn't get to the site.

He remembers cell phones being operable at first and then crashing until they brought in "Cell on Wheels" units. The Public Works channels were free on 2-way radios but there was no way to communicate with other agencies.

Lessons Learned:

Issue #1: Established Relationships

Discussion: Joevan personally knew many of the players. He was able to call them at home or reach them on a direct line, which saved critical time. When there was conflict, the players were forced to sit down and work it out until compromise was achieved (e.g., the engineers each had their own idea of how to handle the building and secure it from collapse; Fire Chief Marrs encouraged players to sit down in a room and figure out one solution.) It was a benefit that Police Chief Gonzales and FBI Special Agent Bob Ricks

were friends prior to April 19, 1995. Although there was conflict, FEMA recognized that they did not have all the answers or the experience and they learned from our local agencies, just as we learned from them.

Recommendation: It is important to establish relationships with other agencies at various levels of jurisdiction so that if disaster occurs, the players already have a rapport with each other and at the very least, know who to call and when. It is smart to have a list of resource names and contact information within the disaster plan.

Issue #2: Planning and Preparedness

Discussion: Cities need to be fully committed to training. The fact that Oklahoma City had sent city officials and key agencies to training in Emmitsburg, VA, was important. Most fought that decision and thought it was a joke, but everyone agreed it was well worth the time off to train. Even though the initial city plan had holes in it, the plan allowed everyone to flex and bend to the incident. At first, the overlap of the recovery with a crime scene caused some conflict between the FBI and the fire and police. By late afternoon, the conflict was resolved and everyone worked together to assist each other.

Recommendation: Invest the appropriate time and dollars for proper planning and coordination of efforts between every level of response. Align resources and practice until every aspect of the plan becomes second nature. Remind yourself as city officials that life does go on beyond a disaster. People still need water, trash service, and protection from crime and fire. Utilize your mutual aid agencies from surrounding communities.

Issue #3: Communication

Discussion: The value of appropriate and adequate information can make the difference between a successfully executed recovery effort and a chaotic one. Keep employees informed on what is happening. They need to be in the loop and filled in on progress being made so they can maintain work and not be dependent on the television.

Recommendation: Develop a process within your plan for regular briefings for employees. When employees understand what is going on, they can be even more resourceful.

Discussion: In the initial hours of the response, telephone lines were nonexistent and cell phones were inoperable due to the large volume of calls. Everyone was forced to communicate with runners and this proved chaotic and confusing at best. It wasn't until later that local cellular companies were

able to bring in extra cell towers to accommodate our needs. The "golden hours" are key to the success of recovery and the lack of communication hindered our efforts.

Recommendation: Include communications providers in your communication plan. They become valuable partners.

Issue #4: Spontaneous Volunteers and Donations

Discussion: Volunteers and donations are a blessing and a challenge. No one could have predicted the amount of people and goods and services that deluged Oklahoma City in the aftermath. This was underemphasized in the city's plan and caused chaos and confusion among the agencies trying to tend to the recovery efforts and process donations and volunteers.

Recommendation: Establish a plan to engage volunteers, yet control them. Your plan should include proper registration with adequate staff to process volunteer information and identification. It is also important to designate a place for donated goods to be dropped off outside of the initial perimeter of the scene. Every plan should identify a sufficient number of people to manage donations and a system to track them.

Issue #5: Resources

Discussion: After the perimeter was secured, there were still hundreds of cars in the area that belonged to people who worked in and around the Federal Building. Amidst all the chaos of trying to begin search and recovery efforts, those people needed to get to their cars. City officials utilized rookie cops from the local rookie school to escort people into the perimeter to get their cars.

Recommendation: Use what resources you can from your local community, but know when to hand it off. Be ready for the unexpected.

Issue #6: Human Element

Discussion: In every step of the process of the recovery effort, the city tried to concentrate on people. If you take care of people, the task at hand takes care of itself. One of the best decisions made was to host the national prayer service the Sunday after the event. This rallied everyone and forced everyone to come together during this event.

The Family Assistance Center was omitted from the city's plan. No one anticipated so many families being affected. This was the one component that no one agency was prepared for and this added to the chaos and confusion in figuring out who was in charge, who needed to do what and what services needed to be in place.

Recommendation: A good disaster plan needs to at least address a prayer service, memorial, etc. The Family Assistance Center needs to include clergy, mental health professionals, food, sleeping quarters if needed, the medical examiner and the Red Cross. Representatives from each of these areas need to meet and plan for this component in a citywide disaster plan and address the key issues.

Issue #7: Mental Health

Discussion: Oklahoma City has handled many natural disasters, but never a disaster of this magnitude involving terrorist activity. Because of its complexity and the number of consecutive days worked, there were many emotional issues that arose. It was important to recognize signs of posttraumatic stress and other issues and intervene where necessary. Even employees who had no direct role at the site were experiencing depression and other problems. Everyone in Oklahoma City was impacted by this event.

Recommendation: Take care of people and their mental well-being. Plan for debriefing and long-term counseling if needed. Pace your people. Assign shifts and stick to those shifts. Even though everyone wants to be involved 24-7, pull them off and force them to rest and invest themselves for the long haul.

## Kenneth Bunch

### Assistant Chief, Oklahoma City Fire Department

See Chief Gary Marrs interview.

## Ann Burkle

### Clinical Coordinator, St. Anthony Hospital Emergency Room

As the hospital's emergency room clinical coordinator, Ann's job is to staff the emergency room and secure all three shifts for around-the-clock care. On April 19, 1995, Ann was on her way to work when the explosion occurred. She encountered major difficulty getting to the hospital as roads were already closed off to secure the area around the hospital. When she finally was able to park her car, she reported to the ER and began triaging patients and assessing the flow of traffic, supplies, and staff. There were not only hundreds of patients, but also hundreds of volunteers, media, physicians and nurses. Patients were coming to the ER entrance by way of foot, truck or car. Within five minutes of the bombing, several hundred wounded were in the triage area of St. Anthony. It was important to treat the patients but, at the same time, Ann had to stage the plethora of volunteers to different areas in

an effort to clear the area for treatment. Additionally, she needed to assess the status of supplies and personnel as well as insure admitting procedures were being handled for each patient.

Lessons Learned:

Issue #1: Disaster Plan

Discussion: St. Anthony had a disaster plan that had been practiced each year. But, the plan did not accommodate large numbers of spontaneous volunteers and family members.

Recommendation: Review and practice a plan so that it becomes second nature during an actual disaster. Ensure the plan is flexible (i.e. diverted patients to different units that have been closed down.). Bear in mind that only in an ideal world will the best laid plans work. Even if you have all the proper processes in place, such as a citywide Family Assistance Center, you will still have family members coming to your hospital wanting to find their family members.

Issue #2: Security of Donated Goods

Discussion: A large number of spontaneous donations of supplies were being dropped off in front of the ER. If any of these boxes had bombs inside them, the effects could have been catastrophic.

Recommendation: Designate in the disaster plan drop off areas for supplies and donations so they can be appropriately examined at the time they are dropped off.

Issue #3: Admitting/Discharge Process

Discussion: St. Anthony had three different admitting areas in three different areas of the hospital. None of the admitting areas had standardized procedures for admitting the large numbers of patients. Some patients left without the appropriate information documented. The staff resorted to follow up phone calls to gather their information after the fact. Additionally, the discharge area was staged in a less visible place and many of the patients were leaving without being appropriately discharged.

Recommendation: Devise a standardized admission process with standardized triage tags that are computerized. As the numbers are scanned into the computer, a sticker can be taken from the tag to place on the patient's hard file. Standardized triage tags can be used for a citywide disaster if a community can implement it. Set up a convenient and highly visible discharge area. It can be a vital link in the system to ensure all proper admitting information was documented. It can also serve as a checkpoint for phone numbers for follow up.

Issue #3: Communications

Discussion: There was NO communication from the site through normal communications channels. The hospital never had a sense of types of injuries or numbers of casualties. The hospital's disaster plan had addressed communications with the local ambulance service, but the local ambulance service had switched frequencies during the incident and failed to tell the hospitals. None of the hospitals could communicate with the ambulance service or each other. (NOTE) If you are the closest hospital to the incident, the majority of patients will arrive on foot and self admit.

Recommendation: Establish a Medical Emergency Response Communications Center (MERCC). This system acts as a clearinghouse for all medical response communications through a central command center. Hospitals could have communicated patient information, ambulance services could have coordinated with hospitals to control patient flow, and communications with the incident command post could have been established.

Issue #4: Media

Discussion: The media is a mixed blessing. They provide the first reports, which is how St. Anthony staff learned the scope and breadth of the event. On the other hand, the media would overhear requests from doctors to nurses and assume what they heard were needs they should announce to the public. One reporter overheard a doctor asking for blood and in minutes several hundred people arrived at St. Anthony to donate blood, which caused even more confusion and chaos.

Recommendation: It is important to work with your local media and control them. Set appropriate boundaries so they are not hindering care for the patients. Use them to control the chaos instead of adding to it and train them on what is appropriate to say and what isn't. Work closely with your security department to control them.

Issue #5: Critical Incident Stress Debriefing (CISD)

Discussion: Emergency Room Personnel are trained to handle trauma, but no amount of training truly prepares one for the level of injuries that occur during a disaster involving magnanimous numbers. Additionally, other hospital staff from other areas are there to assist and they are not trained to handle trauma.

Recommendation: Engage employees immediately in a debriefing process. Allow them an opportunity to talk about their experience and make provisions for the long haul. St. Anthony Hospital's turnover was minimal compared to other city hospitals and the reason for that was stress debriefing for our employees. No other hospital addressed stress debriefing.

NOTE: The events on September 11, 2001 caused flashbacks for many of our employees. They started experiencing insomnia and other symptoms so we are always watching and encouraging employee assistance.

Issue #6: Spontaneous Volunteers

Discussion: It is human nature to want to do something and to want to help. People will voluntarily show up and want to help, but not realize they may be in the way. Everyone has a need to DO something.

Recommendation: Plan for mass quantities of volunteers to show up, medical and otherwise. Assign staff members to register them, credential them if needed, and create tasks for them to handle that will be helpful to the process.

Issue #7: Assigning Resources

Discussion: During the disaster, engineering and medical records departments were non-operational and those personnel could have been used to assist with admitting and discharge or security officers.

Recommendation: Be resourceful and use all of your personnel. Engage them in your disaster plan. Clergy are an important component to the process. Include clergy in your plan to deal with family members not only to identify victims, but also stay with the families while they are trying to locate loved ones.

Issue #8: Appropriate Patient Documentation

Discussion: When faced with treating hundreds of patients at once, the last thing on your mind is documenting treatment in the file. However, this disaster involved federal government employees. In order for the federal government to cover their expenses, they needed appropriate documentation. This is a major conflict for medical personnel who need to treat the patients fast.

Recommendation: The main focus is obviously to take care of the patient first. Try to document what you can. Good documentation saves a lot of steps later. If the resources are available, have a staff person on hand for each patient to dictate treatment procedures.

## John Clark

### Lieutenant, Oklahoma City Police Department
### Office of Emergency Management

April 19, 1995, Lt. Clark was in McAlester, OK teaching survival classes. Another instructor at the school informed Lt. Clark of what had happened. Because Lt. Clark was a trainer, facilitator, and supervisor of the Oklahoma City Police Emergency Response Team, he immediately headed back to

Oklahoma City and checked in at the command post. He first saw several of his ERT's and men in suits and women in heels working on a bucket brigade. He pulled them off the scene because of the instability of the building. He reassigned his ERT's to the perimeter. He then began coordinating with the Medical Examiner's office and the fire department to remove bodies found until the D-Mort Teams arrived.

The Oklahoma City Police Department is the 39th largest department in the United States. As supervisor of the Will Rogers ERT Team, Lt. Clark instructed four ERT teams that rotated 12-hour shifts throughout the disaster. As the shift supervisor for perimeter control, the biggest challenge was keeping family members out of the bombed area and at the Family Assistance Center. Fortunately, the substantial drop in crime throughout Oklahoma City the first week after the incident was overwhelming.

Throughout the course of the seventeen days, the police department made 54 arrests, the majority being trespassers in the area. Nine of the arrests were media staff.

Lessons Learned:

Issue #1: Established Relationships

Discussion: Until April 19, 1995, the OCPD had limited experience working with other agencies on large-scale emergencies. This proved to cause some conflict. FEMA was a problem at first because they wanted to take over command. The U.S. Attorney General, Janet Reno, finally took control and told FEMA to assist. The State Emergency Management Offices offered a lot of assistance and coordination, which helped. This event forced the OCPD to work with FBI, FEMA, Public Works, ATF, US Marshals, National Guard, State Department, and the fire department.

The three chiefs (fire, police, FBI) were golf buddies prior to the Oklahoma City bombing. The fact that they knew each other on a personal level solidified the unified command during the event.

Recommendation: Everyone has to work together at every level. Establish relationships with other agencies and maintain them.

Discussion: Throughout the course of the event, public officials would try to visit the site for various reasons. When the media would see public officials, they would try to follow public officials to gain interviews. This created more chaos and challenges for perimeter control.

Recommendation: Keep public officials away from the area. This is not a time to grandstand. Public officials need to know their role too.

Issue #2: Planning and Preparedness

Discussion: The OCPD didn't have a plan that anyone on the force was familiar with. Because of this, there was confusion and overlap as to who did what. Additionally, steps and actions were taken that could have resulted in further injury. For instance, some of the officers were in the building trying to help rescue and weren't wearing proper protective clothing.

Recommendation: Don't think this won't happen to you. There is no defense against an ambush. Have a plan, use it, practice it so it is second nature, but be flexible with your plan. We now have an Emergency Operations Plan and we practice it so everyone knows their role. Line up your resources ahead of a disaster.

Issue #3: Chain of Command

Discussion: During a disaster event it is important to have a chain of command and establish who is in charge of what. Because the magnitude of the Oklahoma City bombing was so great, there needed to be different commands for the crime scene and the recovery scene and yet everyone needed to work together.

Recommendation: Establish a chain of command before an incident. Practice a unified command structure. 3-4 heads are better than one. ALWAYS prioritize an incident in this order:

- Life safety - triage, treatment, personal protective equipment
- Incident stabilization - to lessen further death and injuries
- Conservation of physical evidence and property
- Environment concern

Issue #4: Human Element

Discussion: Many of the officers weren't able to attend funerals during the recovery efforts. The memorial service at the site after the incident was a valuable and important exercise for the officers.

Recommendation: It is important to take care of staff, rescuers, family members and victims emotionally, mentally, physically, and spiritually.

Discussion: During the recovery efforts, many officers wanted to work around-the-clock. It was also difficult to go home and leave the scene after a shift. Over the long haul, the recovery efforts took their toll on many officers. It was important to force officers to sign off duty and allow others to rotate in so that they could rest up and return sharp and ready to work each day.

Recommendation: Know your limitations, personally, as well as agency-wide. Know your capabilities and don't be afraid to ask for assistance. It is important to rotate shifts and stick to those rotations.

Issue #5: Stress Debriefings

Discussion: Debriefings were mandatory and weren't handled appropriately for the police department. Debriefings weren't being conducted by peers on the force. Because of this, many officers didn't take the program seriously and problems weren't addressed until it was too late in some instances.

Recommendation: Debriefing for the officers shouldn't be forced and shouldn't be facilitated by anyone other than officers. Because everyone grieves differently, different options should be made available. Group debriefings, as well as one-on-one counseling, should be made available and officers need to know it is okay to talk to someone. People will either talk it out or act it out so make sure someone is policing the culture. Wait as many days to debrief as the event took place, i.e., Oklahoma City bombing incident lasted 17 days, so debriefing should have commenced 17 days after the incident ended.

Issue #6: Communication

Discussion: Communication the morning of the bombing was nonexistent. Phone lines were inoperable and cell towers were blocked with so many calls at once. It was not only difficult for agencies to communicate within agencies, but also difficult to communicate between agencies. Cost is a major factor, but communications during an event are critical and there needs to be a backup plan.

Recommendation: Establish solid communication systems. Ensure the disaster plan addresses a backup system. If possible, engage a city-wide communications committee to pinpoint problem areas prior to an event. Oklahoma City finally developed a system of priority cell phone numbers so that during an event those numbers would receive priority service. Additionally, Oklahoma City is working towards an 800 MHz system for all first responders.

Issue #7: Donations

Discussion: Donations of goods and services were showing up from everywhere. The first problem was donations were being brought into the command area, which caused chaos and confusion and could have been a safety issue. Donations were also showing up in duplication. It was difficult to keep up with the donations and account for them. After the event, some vendors came back to get their equipment and it was difficult to determine what was whose.

Recommendation: The disaster plan needs to encompass a plan for control and tracking of personnel, equipment and supplies. There should be a select few coordinating this so that there is the least amount of confusion. Establish

a plan for donations of goods. Donations should NOT be dropped off at the command area unless needed. Make provisions to drop off donations off site and install an excellent accountability system for donated goods.

Issue #8: Spontaneous Volunteers

Discussion: No one anticipated the number of volunteers from other police forces. While it is comforting to know so many wanted to help, it created issues of determining how to register volunteers and assign them in an organized fashion.

Recommendation: It's important to allow volunteers to work, but there needs to be a way to organize, control, and assign them. Ensure the disaster plan addresses this issue.

## Cynthia Cope

### Director of External Affairs, Southwestern Bell

As Director of External Affairs for Southwestern Bell, one of Ms. Cope's jobs was to establish relationships with key leadership in the community. This proved to be one of the single most significant factors in successfully bringing organization to chaos. Communications across the city ceased directly following the explosion. Within minutes, Cope was on the phone with Chief Marrs and other responders ascertaining their needs. Phone communication among responders was a top priority. With the help of several of her employees, she was able to pull resources together and shortly thereafter, establish telephone lines. Additionally, 1,500 cell phones were distributed throughout the response community. Southwestern Bell also established free pay phones for media personnel and converted the Southwestern Bell Headquarters to the incident command post for all of the responding agencies.

Lessons Learned:

Issue #1: Established Roles

Discussion: Within the critical first hours of the disaster, Cope was communicating directly with Fire Chief Marrs, the Mayor, and Police Chief Gonzales. Because of her relationship with each, she was able to extend any and all needed services to the key personnel quickly and effectively.

Recommendation: Establish relationships during the planning and training exercises. Get to know those in charge and establish a line of communication so everyone knows what resources are available during an emergency.

Issue #2: Planning and Preparedness

Discussion: Southwestern Bell had a disaster plan that provided a flow and organization for evacuating the building. This proved beneficial in the first minutes following the explosion to properly account for personnel and assess damage to the building efficiently. Once the building was evacuated, many employees were sent home, but many still needed to help facilitate service, etc. to the community. It was important to have flexibility in the plan to adjust and act according to the situation.

Recommendation: Ensure a flexible plan that allows for provisions beyond the normal and routine planning. Ensure the plan flows smoothly so daily operations can coincide with the operations needed for a disaster. The community still needs phone service in spite of a disaster.

Issue #3: The Human Element

Discussion: During the aftermath, the building was converted to a command center for multiple local, state and federal agencies. The CEO's office bathroom became the showers for the USAR Teams. It was important to take care of needs as they arose. SWB personnel ordered cots for people to sleep in, organized a laundry service for their clothing, and set up a cafeteria to feed people over the 17-day event.

Recommendation: Recognize and handle any and all needs.

## Stephen Cortright

### Adjutant General, State of Oklahoma National Guard

General Cortright was installed as Adjutant General on April 1, 1995. Two days prior to the bombing and in the height of flood and tornado season, he had reviewed the National Guard's State Disaster Plan with Governor Keating. At 9:02 a.m., April 19, 1995, General Cortright was on his way to the Capitol and upon his arrival he went immediately to the Governor's office and began making calls and ensuring incident command was in place.

The Press had already requested a statement from the Governor and so as part of that conference, General Cortright announced to the public to avoid the downtown area and avoid the disaster. He then began assisting and supporting incident command to help protect his area.

Lessons Learned:

Issue #1: Communication

Discussion: Communication systems were antiquated at best. The Emergency Operations Center, where the General and Governor were most of the day, did not allow cell phone penetration and hard lines were limited. Even-

tually, the EOC was moved to the Southwestern Bell headquarters along with other local, state, and federal agencies. This improved communications, but it was much later in the day.

Recommendation: State disaster plans need to include an adequate communications system for every response agency involved.

Issue #2: Planning and Preparedness

Discussion: At the time of the disaster, the National Guardsmen were not trained for crime scene protection. They were asked to protect the crater for evidence so their role became that of preserving the crime scene while not delaying or interfering with the rescue. National Guard was asked to set up three rings of security: the screening area, the interviewing area, and special permits area. National Guard was the only agency that was involved in every phase of the operations. Guardsmen were firefighters, dentists, doctors, security, sifting site, chaplains, and security for the Family Assistance Center. The individual training for each task was sufficient, but multi-task training would have been helpful.

Recommendation: Training and skill level allow responders to respond well and perform tasks as though it were second nature. Ensure a plan that provides for the various levels of agencies involved. There needs to be training that co-mingles civilian and military participants. When the federal government brings in resources for incident command, they want to control their assets, but the way the military commands (Top-Down) does not blend well with incident command, which is bottom up. We need to constantly work a broad-based plan to include all levels of terrorism and we need to maintain an attitude of not if, but when. The mental attitude should be that it could happen any time.

Issue #3: Spontaneous Volunteers

Discussion: Volunteers were showing up in mass numbers. They needed to be credentialed and processed. It is human spirit to want to fulfill their desire to serve, but it must be handled in a controlled and organized fashion.

Recommendation: The disaster plan should identify roles and positions for volunteers before a disaster.

Issue #4: The Human Element

Discussion: No matter the role you play, the emotional stress can be just as taxing as the laborious work. Regardless of how you feel, the mind and body need rest for the long haul. Families need to be consistently informed. During an incident like this one, families grew edgy when they weren't receiving news. They didn't understand why the process took so long. Communicating with them and helping them understand can be critical to the outcome. It's

important to anticipate what they want to know and to always be keeping them informed of what's happening and the next step. This enemy was very different. The fight was against emotion. Everyone had to learn to channel energy toward the rescue efforts.

Recommendation: Limit shifts. Assign shifts and stick to them. Have a process in place to tend to people's emotional and physical well-being.

Issue #5: Established Roles

Discussion: Critical to the site sifting area was the way it was managed. The FBI kept the soldiers motivated by encouraging their work ethic instead of the emotional level. They were divided into teams and each day they would be briefed as to what was found and how it benefited the investigation. This provided the soldiers a constant motivation to keep finding evidence and to focus on the outcome.

Recommendation: Attitude is everything. What made this event successful was the attitude and spirit of Oklahoma people. If there were conflicts, they were met head on behind closed doors and compromises were made. Everyone was willing to work together for the cause. Personal agendas were left at home.

Issue #6: Resources

Discussion: Oklahoma responders embraced the help from Urban Search and Rescue (USAR). This was extremely beneficial to the success of the outcome.

Recommendation: Recognize your limitations. Where possible, call in the experts to assist.

Issue #7: Family Assistance Center

Discussion: The Family Assistance Center proved to be the most difficult area to secure because of the media. The FAC was and still is one area needing to be addressed in terms of an established chain of command. There were several players trying to provide a service to families and because no one entity was in charge, there was chaos and confusion.

Recommendation: The Red Cross, National Guard, clergy, and mental health professionals need to meet and establish roles and responsibilities prior to an event.

## David Dagg

### Director of Safety and Security, St. Anthony Hospital

At the time of the bombing, David was in his office on the third floor of St. Anthony Hospital, located just 5 blocks north of the Federal Building. His responsibilities at St. Anthony include overseeing all security issues at the 2-block campus, as well as overseeing the safety committee for the hospitals.

When he heard the blast, he assumed it was an internal explosion. Initially he radioed his security officers to ascertain what had happened. Once he realized the explosion was downtown and understood the magnitude of the event, he alerted the Emergency Room and administration to activate the hospital's disaster plan. He then assessed the hospital's damage and began calling for additional security.

St. Anthony received hundreds of victims within the first 7 minutes. Approximately 100 were critically injured and the other 300 were minor injuries. David noted that 85% of victims in a disaster will self refer to the closest hospital. Of the 100 critically injured, 35 were admitted to the hospital. Simultaneously hundreds of family members and volunteers came to St. Anthony looking for family or wanting to help.

Lessons Learned:

Issue #1: Established Relationships

Discussion: It would have been helpful to have better relationships with key disaster response agencies. There were no provisions in a citywide disaster plan to communicate with the site commander. It would have helped to establish relationships between the hospitals so information could have been shared with family members looking for loved ones at various hospitals.

Recommendation: Hospitals need to be included in citywide disaster planning and preparedness. Through established relationships, communication flows and operations run more smoothly.

Issue #2: Communications

Discussion: Internal Communications - St. Anthony was deluged with victims and family members. The campus was accepting patients at three different locations. It was impossible to communicate from the treatment areas to the family assistance area because phone lines and cell phones were blocked. The hospital had to resort to runners, which was slow and inefficient.

Recommendation: Improve communications internally by purchasing more 2-way radios to communicate rather then cell phones.

Discussion: External Communications - The hospitals should have the ability to share patient information with other hospitals and family members through a clearinghouse to avoid confusion. At the time hospitals were faxing patient names back and forth for family members to view at each hospital. This could have been sent directly to the Family Assistance Center. Additionally, with regard to transportation of patients to St. Anthony, EMSA had switched radio channels so St. Anthony was no longer able to communicate with EMSA. The hospital had no idea how many patients to expect or the types of injuries to expect.

Recommendation: Externally -Establish a Medical Emergency Response Communications Center (MERCC). This system acts as a clearinghouse for all medical response communications through a central command center. Hospitals can communicate patient information, ambulance services can coordinate with hospitals to control patient flow, and communications with the incident command post can be established. Be proactive in involving the hospitals in a citywide plan that includes communication between the site, EMSA and the hospitals.

Issue #3: Spontaneous Volunteers

Discussion: It is human nature to want to do something and to want to help. People will voluntarily show up and want to help, but not realize they may be in the way. Everyone has a need to DO something.

Recommendation: Plan for mass quantities of volunteers to show up, medical and otherwise. Assign staff members to register them appropriate, credential them if needed, and create tasks for them to handle that will be helpful to the process. Make sure doctors and nurses coming in to help are fully credentialed and have a checkpoint for them to register in and out.

Issue #4: Stress Debriefing

Discussion: Recognize the importance of stress debriefing for ALL hospital personnel. St. Anthony offered regular debriefing for all staff.

Recommendation: Offer stress debriefing to employees immediately. St. Anthony brought in The Alleghany Company out of Pennsylvania a week or two after the bombing. They trained St. Anthony staff to train and help other employees. This was highly useful, but should have been implemented ahead of time so that debriefing could have been available the first day to those who first responded to the ER and saw some of the mass casualties

Issue #5: Media

Discussion: Media is a mixed blessing. They provide the first reports, which is how St. Anthony staff learned the scope and breadth of the event. On the other hand, the media would overhear requests from doctors to nurses and assume what they heard were needs they should announce to the public.

One reporter overheard a doctor asking for blood and in minutes several hundred people arrived at St. Anthony to donate blood, which caused more confusions and chaos.

Recommendation: Establish relationships with local media before an event. Educate them prior to disasters of what is appropriate and what is not. Help them understand the hospital's role so they can become an ally. During an incident, offer routine briefings. Hand them stories so they don't create them.

Issue #6: Backup Resources

Discussion: St. Anthony's backup plan for additional security was to contact local security companies. Most of these companies relied on off duty Oklahoma City Police personnel. Due to the magnitude of the event, there were no security personnel available. The hospital resorted to deputizing several hospital personnel from engineering to assist.

Recommendation: Do not rely on other resources within the city for a catastrophic event. Include a plan "B" and enlist hospital personnel resources. Practice and facilitate appropriate training for these individuals during drills.

Issue #7: Disaster Planning and Practice

Discussion: The hospital had routine disaster drills twice per year. For the first 45 minutes, personnel followed the plan verbatim. After the first hour, several variations to the plan were made:

- In the hospital's current disaster plan, the dental clinic, located immediately down the hall from the ER, was designated as the minor injury area. Due to the mass numbers of victims coming in to the ER at one time, the dental clinic became the secondary ER. In essence, there was no minor injury area. Consequently, too many non-critical patients were not triaged to a separate area thus causing confusion and crowding.
- The disaster plan's Volunteer Center location had to be moved three times to larger areas in order to accommodate the number of families.
- The Family and Visitors Center as designated in the plan, was located in an inconvenient area of the hospital. It wasn't aptly equipped with computer ports or telephones and so information could not be routed in a timely fashion. In the future the hospital will work with the city to establish a city-wide family assistance center separate from the hospital.

- A drop off for medical supplies was not set forth in the original plan. Now the plan specifies supplies can ONLY be dropped off at the distribution center of the hospital so that boxes can be adequately inspected, allocated and distributed.
- The plan designated key personnel to designated areas but there was no provision to appropriately identify them to everyone.
- In the original plan there were key channels of communication with EMSA, but no source to communicate with an incident command post on status of victims incoming etc. It would have been helpful to establish communications with the incident command post to routinely receive updates and regular communications.

Recommendation: Review and practice the plan so it becomes second nature. Allow for flexibility in the plan, but ensure the plan is all encompassing.

## Dr. Bryan Farha

### Professor At Oklahoma City University and Oklahoma Licensed Professional Counselor

Dr. Bryan Farha was sitting in his office at Oklahoma City University and heard and felt the explosion. He remembers classes going on in spite of what was happening downtown. His home, which was located within blocks of the bombing, sustained minimal damage. Dr. Farha remembers pieces of his chandelier on the carpet and books knocked over on shelves.

Within days after the bombing Dr. Farha received a phone call from a colleague asking him to donate time at the site to informally counsel the rescue workers. For three consecutive days, Dr. Farha and two of his colleagues rotated shifts at the site talking with rescue workers and helping them deal with the task before them.

The first night he checked in, it was raining hard and the wind was blowing rain right into the faces of the rescue workers. He remembered checking in at the command post and waiting in a long line to receive a photo ID, which allowed him access to everywhere but inside the AP Murrah Building. During the interview, Farha had the photo ID sitting on the table.

Dr. Farha recollected less than 25% of the workers wanting to talk with him. Most were fixated on the building. "It was painfully obvious they wanted to be doing something and standing around waiting for their shift was agonizing.", said Farha.

On the first and fifth anniversaries of the bombing, Farha volunteered with the telephone hot line. As a community, Oklahoma City was progressing quite well until the events of September 11, 2001. Much of the progress made on patients who sought counseling has to be redone. The approach should not be to avoid thinking about the situations, but to deal directly with them and to work through those issues. Mental health professionals cannot eliminate symptoms or problems, but can only minimize the anxiety levels and teach patients to cope more effectively with each day.

Lessons Learned:

Issue #1: Prioritize Physical Safety First

Discussion: During the recovery efforts, Dr. Farha noticed some rescue workers talking in dangerous areas near the building. As shifts were lining up to rotate into the building, they were standing under floors with filing cabinets hanging above them discussing and planning strategies for recovery. Dr. Farha recalls how dangerous this was and how fortunate Oklahoma City was for not experiencing other injuries during the aftermath.

Recommendation: Establish an appropriate "zone" or barrier for non-working responders to stay within until the area is safe. Minimize exposure to harmful zones and maximize time in safe zones. Planning should only occur in safe zones and harmful zones should be avoided whenever possible.

Issue #2: Planning and Preparedness

Discussion: There was no established plan for mental health needs for workers at the site. In the early stages of the bombing, efforts to organize something may have contributed to the chaos due to the various types of mental health professionals. It is important to find a way to include all volunteer mental health professionals in an organized fashion to maximize coverage for those who need it.

Recommendation: Assemble an organized group within the mental health care community and plan ways to organize volunteers to maximize mental health to everyone in the community who needs it. Establish relationships and networks ahead of time so that during a disaster everyone understands their role and place.

There is a need to involve all disciplines in the planning such as chaplains, counselors, psychologists, psychiatrists, massage therapists, etc. so that everyone can be part of the plan to minimize stresses and anxieties.

Issue #3: Appropriately Research Mental Health Techniques

Discussion: There is cumulative stress worldwide. Because everyone handles stressful events differently, problems cannot be tackled with a cookie cutter approach. It is important to research all the possible counseling techniques to minimize stress. Further, the mental health community needs to take a holistic approach utilizing multi disciplines. Mental health includes more than mental factors…it includes diet, lifestyle, etc.

Recommendation: Mental Health Professionals and their agencies need to work closely to support and advocate any and all research on diets, vitamins, airborne contaminants and pollutants, etc., to help minimize anxiety and help society deal with day-to-day stresses. All are integrally important to a comprehensive recovery.

Issue #4: Long-term Mental Health Needs…The Human Element

Discussion: It is important for the rest of the world to note that Oklahoma City is still dealing with issues from the Oklahoma City bombing. People cannot be expected to perform near peak proficiency for a minimum of at least a year following a major disaster. Employers and supervisors need to recognize this and work to provide ways for employees to cope.

Recommendation: Employers, corporations, supervisors, and managers need to provide seminars and workshops on coping and recognizing stresses or signs of depressions or other conditions. These should take place approximately once a year for at least five years following a disaster. The employee assistance program should also be considered and made available to address employees' needs. Society as a whole needs to address long-term needs and realize the short-term, quick fix approach doesn't work.

Issue #5: Spontaneous Volunteers

Discussion: It is human nature for people to run to the scene and want to help. However, this tends to cause chaos and adds to the problem instead of helping. Volunteerism is a wonderful thing, but without a proper plan to direct volunteers, everyone is confused and becomes part of the problem.

Recommendation: Community leaders need to appropriately address volunteer organization and channel it through one agency such as the Red Cross. Volunteers need to be educated and trained to check in and register prior to events and then wait to be called upon to help.

## Jeannine Gist

### Family Member

Jeannine was at work the morning of April 19 at Tinker Air Force base. She heard the boom and instantly thought it was a sonic boom. When she realized what had happened, she called one of her daughters who worked in the

Southwestern Bell complex close to the Federal Building, but she couldn't determine which building was affected due to the smoke. Her youngest daughter, Karen Gist Carr, worked as an advertising assistant in the US Army Recruiting offices within the Federal Building. A co-worker took Jeannine home where she waited to hear from her daughter.

Once her family got together, they went to St. Anthony Hospital and watched as names were placed on butcher-block paper. They kept hoping to find Karen's name on one of the lists. Later in the day, they went to other hospitals hoping Karen would be there.

The following day, she and her family reported to the FAC and waited all day for news. Jeannine found this to be a difficult place to be. People were upset, confused, and waiting for news. The Army told her they would notify her at home if she wanted to wait at home. She and her family waited for news at their home.

On the night of the tenth day, they found her daughter. Army personnel and a chaplain notified her. They presented her with an American Flag and a lapel pin. She said it was the first time in history a civilian family had been presented a flag from the army. Typically, this is only done for service members during wartime, but the Army told Jeannine they felt she died for her country.

The Prayer Service

Jeannine did not want to go to the prayer service, but attended for her family. She felt it was too early in the process and as a family member, she should have been given more time to deal with the tragedy. The service was held only four days after the bombing and most of the victims, including her daughter, had not been recovered yet. She was still hoping for her daughter to be rescued and yet, they were talking about a "time to heal." Her observation of the service was it was more for the world then it was for her and other victims' family members.

Site Memorial

On the day before the implosion, a site memorial was scheduled. Jeannine did not want to attend, but did so because she felt she might regret it later if she didn't see the building before it was demolished. To this day, she feels ambivalent about going.

The Memorial Process

The Memorial process was unique, difficult, but necessary to the healing. Not long after the incident, family members were notified of a meeting at First Christian Church to discuss a possible memorial. Even though she felt it was too soon, Jeannine wanted to attend because she wanted to know what the plans were. Immediately there was no trust. She felt "they" were using

her daughter's death to gain civic awareness and to promote Oklahoma. She was deeply concerned about motives and had a strong conviction that no one should capitalize on the tragedy.

The meeting, which was held in the same location as the Family Assistance Center, brought out bad memories and put family members in a very uncomfortable position. Many did not want to be dictated to and wanted some control of the situation.

Family members, survivors, and rescuers were invited to attend. The group was slow to include rescue workers, but soon understood the need to do so. The dynamic of placing three very different groups into one setting proved to be a challenge. Family members were mourning the loss of loved ones who they felt needed a voice in the process. Some resented the fact that survivors were there in the first place, while some survivors were feeling guilt about surviving. Rescue workers felt sympathy grief and frustration that they couldn't save more people.

Over all, the family members and survivors learned to work together and voice their opinions in a respectful manner. Jeannine felt it was important to the process to seat participants at round tables with mental health professionals present at each table. Serving as moderators, they were able to help participants channel their emotions into constructive words and develop a unified mission statement.

She believes Oklahoma City conducted the process absolutely the right way by including the family members and ensuring their involvement in the process. In fact, she identified when Bob Johnson hired a consultant from the Vietnam Memorial. The consultant insisted family members not be involved and so the relationship with the consultant ended. Bob developed the family members' trust by including them in all the planning for the anniversaries and activities centered on the Memorial.

Jeannine was initially opposed to using the word "hope" in the mission statement. It was difficult for her to understand how anything associated with the tragedy could bring hope. With time she still has struggles with it, but has compromised for others who need that word in the mission statement.

The Memorial

The Memorial itself is a beautiful tribute to those lost and to those who suffered. As a volunteer, Jeannine appreciates the opportunity to assist people, tell her story and answer questions. Volunteering at the Memorial is helpful to Jeannine.

The Trials

During the trials Jeannine was an impact witness, which was very important to her. She needed to tell the world about her daughter and how her loss devastated the family. She wanted to know the individuals involved were brought to justice. She felt the judicial process was swift and commended the Federal Government on their fast actions and the thoroughness of the investigation. She came to trust and admire the prosecuting attorneys.

She feels strongly that Terry Nichols needs to be convicted on a state level to eliminate any chance of him ever being released.

September 11, 2001 was another tragic day for our country. It opened many wounds for Jeannine. She did travel to New York and rode the ferry that took family members to the site. She felt it was beneficial to the 9-11 family members, but has no desire to go back.

As a family member, Jeannine has several issues. If there is anything, she wishes she could have been done differently, she still wishes there would be an accounting of the Governor's fund. She feels that is owed to the family members and survivors. Everyone knows the minor children of the victims received funds for college educations, but what about the rest of the money? People sent money earmarked for families of victims and she would like to know how many families received assistance.

## Sam Gonzales

### Chief of Police, Oklahoma City Police Department

As Chief of Police, Sam Gonzales spent the morning of April 19, 1995, with 1,200 other civic leaders and clergymen at the Annual Mayors Prayer Breakfast. Afterwards, he went to his doctor to treat his allergies. At the time of the explosion, Chief Gonzales thought the Allergy Clinic's elevators had fallen. When he realized that was not the case, he phoned headquarters and ascertained what had happened.

He drove immediately to the site, met with Fire Chief Marrs, and then initiated his Emergency Response Teams and had them report to the scene. The first hour and a half was spent trying to gain control of the perimeter, which was difficult since it was a 20-square block area and there were so many community members wanting to find their loved ones. At 10:30 a.m., a bomb threat became a blessing in disguise and allowed him the opportunity to gain control of the inner and outer perimeters of the building.

With the support of approximately 450 personnel from other area police departments, the Highway Patrol and the National Guard, Chief Gonzales remained in charge of the security of the area and assisted the Federal Government in setting up and running the crime scene.

Lessons Learned:

Issue #1: Established Relationships

Discussion: Fire Chief Marrs and Chief Gonzales were good friends, which proved to be a major factor in the communication between the two. Additionally, all of the city's key personnel participated in a disaster drill in 1994 in Emmitsville, MA. This drill not only provided practice for key personnel, but it allowed them an opportunity to build trust and relationships with key players prior to the incident. Some of the problems in the breakdown in communication involved local agencies trying to work with federal agencies. It would have been helpful if those relationships had been established prior to the disaster.

Recommendation: Build relationships with FEMA before an incident. Work with local FEMA personnel before an event to determine what steps should be taken. Establish rapport and meaningful relationships between key incident command personnel before an incident occurs.

Discussion: It took the entire community to respond to the Oklahoma City bombing. No one group could have handled it alone. The resources of everyone are important and personal agendas should be left aside.

Recommendation: Know in advance who is responsible for what roles during an event. Practice with those players on a regular basis.

Issue #2: Communications

Discussion: Communications was and remains a problem. At the time of the bombing, the fire department, police department and EMSA were on different radio frequencies. Responders had to resort to runners, which slowed down communications and caused some miscommunications. Southwestern Bell brought in 1500 cell phones, which helped, but cell phones are not the most private means of communication.

Recommendation: Establish a plan for communication. Have a resource available for 2-way radios. Designate a Communications Committee for your community. Identify communications partners and enlist them as a resource.

Discussion: It was critically important to communicate daily with other agencies to compare notes and brief each other on progress, concerns etc. Two daily briefings were established with the FBI at each shift change. This provided a unified command for everyone to hear updates at the same time.

Recommendation: Add daily briefings between agencies into a disaster plan so that everyone is on the same page and hears information at the same time. This also allows you to make unified changes to the plan and recovery if need be.

Discussion: It was determined early on that Governor Keating would be the spokesperson for the state. Media briefings were split up according to jurisdiction.

Recommendation: Communities should include public officials in the disaster plan. They are the voice of the people and need to be included. It should be established up front what is appropriate to report and when to and not to say things. Decide this ahead of time.

Discussion: In the early hours of the incident, it was difficult to get a handle on how many casualties there really were. It was critically important to find out how many potential survivors and bodies there were. Oklahoma City established a hot line at the Mayor's office for survivors and family members to call in names. The media helped filter the hot line number to the public.

Recommendation: Make sure your plan includes the establishment of a resource hot line through a single source to determine survivors and casualties.

Issue #3: Media

Discussion: The media was reporting fabricated stories with many assumptions. In retrospect, if key personnel would have given priority to the media and public information officers would have understood their roles during a disaster, the rumors would have been kept at a minimum. The first formal press conference for the media was not until 4:00 p.m. on April 19. The media was telling doctors and nurses to report to the scene. This created a huge problem because volunteers were reporting to the scene and no one had any way of knowing if they were credentialed or not.

Recommendation: Give the press timely and factual information so they won't create stories. As part of a disaster plan, key medical personnel should be pre-credentialed and that information be on file at local hospitals.

Issue #4: Donations

Discussion: Donations were overwhelming. Goods and supplies were showing up in droves. Often the same item was donated by several different agencies creating mass duplication. Further, there was no process for handling, accounting, and acknowledging donations. After the incident, several agencies who brought supplies and equipment wanted things back and there was

no way to track whose was what. Additionally, FEMA offers coverage of disaster expenses IF they are properly documented and appropriate protocol takes place.

Recommendation: A methodology should be pre-arranged so that appropriate acknowledgement of donations can occur and it can be predetermined where the donations go and how duplication of supplies etc., can be kept to a minimum. Personnel should be assigned to this duty so everyone knows who is responsible.

Issue #5: Stress Debriefing

Discussion: Stress debriefing is critical. OCPD began stress debriefings on the third day. Every police department should establish critical incident stress debriefing (CISD) early on and provide it long-term. Additionally, it should be available not only in groups but anonymously as well. Also, it is imperative that officers debrief officers.

Recommendation: Make provisions for stress debriefing. Involve professionals in the process to train key personnel to look for trouble spots on the force. Educate officers that it is okay to talk about issues and problems. In the long run, everyone is better off.

Issue #6: Identification

Discussion: ID badges were a major issue. Because there had been no thought out plan of who should and should not be allowed in the inner perimeter, it was being handled case-by-case. The number of people trying to get in was huge. It was uncontrollable and chaotic.

Recommendation: Communities should determine prior to a catastrophic event who should have the authority to issue badges and who should be granted access. Determine who has jurisdiction so that doesn't become an issue during an event.

Issue #7: Spontaneous Volunteers

Discussion: No one could have predicted the number of spontaneous volunteers that showed up from all over the world. Surrounding police departments and officers from other departments across the country were showing up to help. Unfortunately, this created another set of problems for personnel trying to deal with the sheer numbers of volunteers wanting to help, registering them, and assigning them.

Recommendation: Have a strategy for dealing with volunteers ahead of time. Everyone wants to help but sometimes too many volunteers, who may or may not be qualified, can get in the way. Educate other forces to stay away until ASKED to help so they don't become part of the problem.

Issue #8: Planning and Preparedness

Discussion: All of the city's key personnel had participated in a disaster drill in 1994 in Emmitsville, MA. This drill provided practice for key personnel and enabled them to make decisions and coordinate efforts efficiently. Although the disaster drill did not accommodate multi levels of agencies, it galvanized the relationships at the local level and provided planning and preparedness that was critical during the bombing recovery.

Recommendation: Take the time to implement a diverse and comprehensive disaster plan and then practice it over and over so everyone is comfortable with their role.

Discussion: The initial command post was set up too close to the building. In the event of a second bomb, the command post and its key personnel would have been eliminated.

Recommendation: Make sure your plan affords a well thought out plan of action for a command post that will be secure for several days of an event. When setting up an initial command post, consider all the possibilities.

Discussion: Oklahoma City had never dealt with a multi-tasked incident where recovery and crime scenes needed to work together. Communities need to remember the order of importance in an incident: Life Safety first, then collection of evidence.

Recommendation: Make provisions in the plan to include the priority if an event requires more than one mission. Educate all key players so everyone understands the priority.

Discussion: Educate first responders and key volunteer personnel on who is allowed into the inner perimeter and who is liable if something should happen.

Recommendation: Ensure the disaster plan outlines roles and responsibilities of personnel during an event.

## Marsha Gregg

### Small Business Manager, Greater Oklahoma City Chamber of Commerce

Marsha's responsibilities at the Chamber included liaison to the small business community and to the members at large. The morning of April 19, 1995 started at a seminar at Applewoods Restaurant. She felt the reverberations from the bombing and attempted to go to her office. On the way to her office, she met fellow employees on the street and was told they had been sent home for the day. She spent the next several hours watching television and contacting family.

Within the first twenty-four hours, the President of the Chamber called a meeting with key staff and outlined their mission during this event. The Chamber would oversee two areas: Media relations concerning Oklahoma City's image and assistance to affected businesses. Marsha's office mailed a Damage Assessment Survey to 1,727 businesses from select zip codes covering the impacted area (approximately 5.5 square miles). An Emergency Business Assistance Center was established and Chamber staff coordinated a business command center staffed with volunteers from area chambers and business community. The Center's main objective was to get resources for recovery to those companies that needed or wanted help.

For the next several months, the Chamber's Emergency Business Center served as a clearinghouse of information from FEMA, the U.S. Small Business Administration, and the Small Business Development Center, supported by USSBA and University of Central Oklahoma. United Way and local authorities provided business access to damaged areas and worked with other agencies to coordinate resources, services and assistance to affected businesses. They continued calling (more than 4,200 calls logged) to businesses to verify status and needs and served as an outlet to communicate with the media. Through an established case management system, they were able to help businesses with extreme needs to locate assistance. They also served as a receiving point and developed an inventory of donations: monetary, office space and furnishings, services, etc. Once a Business Relief Fund was established, monetary donations from private businesses and chambers across the country were collected and made available to businesses with smaller losses based on criteria, application process, screening, and award of grants.

Other sources of funding came from the U.S. Small Business Administration - $6.8 million in low-interest loans for physical and economic damage

a. Physical - 83 business applicants with 45 approved for $5.7 million

b. Economic - 45 approved for $1.1 million

The Chamber Emergency Business Center also secured a grant from the Oklahoma City Community Foundation to hire a professional to coordinate business application to Oklahoma City as administrator of the funds.

Five to nine months later the Oklahoma City Council reallocated $600,000 Community Development Block Grant funds through forgivable loans capped at $10,000 per applicant. The Chamber initially screened 60 applicants. An additional $39 million in congressional aid was allocated to Oklahoma City and a portion of that was earmarked to businesses.

Lessons Learned:

Issue #1: Planning and Preparedness

Discussion: The Chamber did not have a disaster plan and, therefore, none of the employees knew what to do. Many could have effectively assisted the first day, but had no plan in place to organize or communicate.

Recommendation: Establish a disaster plan for the Chamber. Practice routine drills so that everyone understands their role and what is expected of them.

Issue #2: Communications

Discussion: Communications were vital to organizing, coordinating and accomplishing our objectives. Because phone lines were jammed with emergency rescue calls, there was no means to effectively communicate the first day.

Recommendation: Have a backup plan for communications among personnel. Minimize phone use for rescue efforts.

Issue #3: Established Roles

Discussion: Playing an active role in helping others helped us to channel our energies in a constructive and helpful manner. It's important to keep a routine.

Recommendation: Where possible, Chambers should try to establish plans to help communities through an organized process.

Issue #4: Proper Screening and Application Process

Discussion: Over 370 businesses reported damage. It was important to help them process claims and find sources to assist them in rebuilding their business. Further, the longer a small business is down, the harder it is to maintain customer base.

Recommendation: Chambers should take an active role in responding to the needs of the small business community. If possible, establish an Emergency Business Center plan within the Chamber plan and inform and educate Chamber members of the service in the event of a disaster.

Issue #5: Human Element

Discussion: Many of the businesses utilizing the Emergency Business Center were emotionally distraught. Often times employees and volunteers of the Chamber found themselves counseling and lending support to small business owners and their staff.

Recommendation: Staff should know of available resources to recommend to those needing personal counseling.

## Mike Grimes

### Captain, Oklahoma Highway Patrol

See Gary Adams, Chief, Oklahoma Highway Patrol

## Sue Hale

### Executive Editor (Assistant Managing Editor on April 19, 1995), *The Daily Oklahoman*

Sue's morning started at a meditation with some of her friends. On her way to the office, she heard a noise and thought it was a sonic boom. She looked to her right, saw a cloud of smoke then headed to the office.

The moment she arrived at her office she sat down with the other assistant managing editor and the managing editor, watched the television, and started strategizing how to handle the situation. They decided to completely focus on the next day's edition as opposed to creating an "Extra Edition" to distribute that afternoon. They called in all reporters on and off duty and called on retirees still in the area to supplement staff.

They "took down the walls of the departments" and reorganized the paper into five divisions with five editors and staff reporting to each. Divisions included:

- Damaged buildings
- Criminal Investigation
- Survivors and injuries
- Obituaries and deceased
- Local, state and national reaction

Lessons Learned:

Issue #1: The Human Element

Discussion: Make a pact with all media to remember the families involved. Most Oklahoma media personnel agreed not to cover the funerals of the victims. The newspaper set up a system with a column on "how to help and how to get help." The newspaper also developed a profile column to put a face with each victim in an effort to personalize them.

Recommendation: Utilize resources as media to help the families. Be respectful of the victims involved. Don't get in their faces.

Discussion: Allow staff to feel and to interact and build a sense of community spirit at work to help everyone through a tough time. The Oklahoman brought in meals for two weeks to allow them to eat together and counsel each other. A mental health professional was also available to staff for counseling services if they needed it.

Recommendation: Take care of staff. Take care of the editors and yourself. Everyone needs debriefing and the ability to go home and rest.

Issue #2: The Media

Discussion: Reporters from every station were interviewing different spokespeople from different agencies. They would then broadcast the need for blood, doctors, nurses, etc., which caused chaos. A single source spokesperson from one agency can eliminate that confusion.

Recommendation: Appoint a central spokesperson within your disaster plan so that person can identify what is needed and report the correct information. Don't throw out the rules just because it's a major event. Report news and back it up with credible sources. Don't report rumors.

Issue #3: Established Relationships

Discussion: As national and international media personnel arrived at the scene, they were working every angle to get stories. Many media staff went to great lengths to get to victims and family members. Some even dressed as doctors or rescue workers to get into places media were not allowed.

Recommendation: Set ground rules with the national media. You can be cooperative but they will want to use your angles and your connections. Just say no. If you establish relationships with your local law enforcement ahead of time, you can protect your reputation from some of the unethical stunts some national media may try to pull.

Issue #4: Return to Normalcy

Discussion: During the disaster it's very easy to get so caught up in the emotion that stories keep coming. Reporters keep finding new angles on the same stories because emotionally everyone is still healing.

Recommendation: Know when to stop coverage and move forward. Be responsible to your community. You can create an online archive for those who want to continue reading, but move forward so your community can heal. On anniversary dates, don't go overboard on coverage. Be respectful. We present the list of victims and cover the news. That's all.

Issue #5: Communications

Discussion: During the first several hours, reporters were on site with no way to communicate. Safety was an issue as well as communicating news. It would have been helpful to have a plan in place for radio communication. The newspaper also set up a command post close to downtown for reporters to drop off film and grab notes, etc.

Recommendation: Establish a backup for communication. The Oklahoman now has 2-way radios. Cell phones may not work.

Issue #6: Relationships with Other Media

Discussion: At first, other media from all over the world wanted our stories and our contacts. Recognize when it's okay to share information.

Recommendation: Let down your barriers with other media sources. Work together. It's everyone's story.

What news managers or editors can do during coverage of a disaster or tragedy:

- Offer meals during first days or weeks then gradually end these so they will be encouraged to go elsewhere and return to normalcy.
- Ask and listen. Ask if they have a problem and then listen. Encourage them to talk to others who have faced similar situations. Send e-mails or memos that offer encouragement/reminders/the day and date/tips to alleviate stress/letters and notes from readers.
- Let reporters say "no." If they are emotionally or physically spent, let them know it is okay to say no.
- Let reporters take breaks. Allow them time to get away from the coverage, to participate in family gatherings, to attend a sports event, to do a hobby or to simply get away. You may need to order a very driven reporter to take a day off.
- Offer counseling and group debriefing.

Reporter's tips:

- Know your limits. Politely express your concerns if you are given a troublesome assignment. Tell the supervisor that you may not be the best person for the assignment and explain why.
- Take breaks for yourself. A few minutes or a few hours away from a situation may help relieve stress.
- Find someone who is a sensitive listener. It can be an editor or a peer, but you must trust that listener will not pass judgment on you. Perhaps it is someone who has faced a similar experience.
- Learn how to deal with your stress. Attend functions that teach you how to deal with stress. Attend a church, find a hobby or exercise. Treat your mental and physical well-being.
- If your problems become overwhelming, seek counseling from a professional. We all need help from time to time. It's okay to ask for help.

Regrets/concerns:

If the Oklahoman were to do anything over, Hale says they would have patted themselves on the back more and proactively campaigned the paper for national awards for its coverage. The writers and photographers did some of their very best work and the newspaper should have been recognized for that.

## Debby Hampton

### Local Volunteer Coordinator (April 1995)
### Current CEO, American Red Cross

April 19, 1995 started as a typical day for Debby Hampton, the local volunteer coordinator for the Red Cross. Within seven minutes of the explosion, members of the Oklahoma County Chapter of the American Red Cross Disaster Action Team arrived on the scene to assist providing first aid and mass care. Debby's role the day of the bombing was to determine what types of volunteers they would need for the disaster, to register them, and assign them to duty. Initially, the request was for first aid volunteers. By 9:37 a.m., the Disaster Team Coordinator for the Red Cross asked Debby to stop sending volunteers.

The Red Cross had three main areas to contend with: providing mass care to those affected, rescue personnel, and volunteers; offering family assistance; and to transitioning the community from disaster operations to ongoing needs. The Red Cross provided housing, food and day-to-day living expenses to many affected families. Total contributed funds earmarked for the bombing relief through the Red Cross, was over $15 million.

Lessons Learned:

Issue #1: Registration and Spontaneous Volunteers

Discussion: The Red Cross was overwhelmed by the numbers of spontaneous volunteers. In order to process and assign volunteers quickly, many were assigned jobs with typical Red Cross identification. After several hours, a process was orchestrated with the FBI whereby only ID's signed by the Local Disaster Volunteer officer were valid. This procedure was time consuming, but necessary. The fact that the site was a crime scene, required all Red Cross volunteers to be screened before entering the site.

Recommendation: Volunteers are the lifeblood to Red Cross, but it is tough to blend trained volunteers with spontaneous volunteers. NEVER assign untrained and non-oriented volunteers to the scene. Ensure the disaster plan provides for large numbers of spontaneous volunteers. Consider a plan where temporary ID's that expire are issued the first hours to the spontaneous volunteers and a unified ID system for all agencies across the board is implemented for registered volunteers.

Oklahoma City's disaster and the response that followed needs to be an example for other communities to model. Follow procedures that are in place prior to the event and ensure that mock disasters occur regularly to test the system in which all agencies that would be involved in a large-scale incident are involved.

Issue #2: Communications

Discussion: The communications problems throughout the city caused major challenges for the Red Cross. Communications had to occur via runners, which also caused breakdown in communications and slowed the process and response time.

Recommendation: Plan for a sophisticated and reliable hand-held radio system. Seek funding for this system prior to an event. It will ultimately save time.

Issue #3: Natural vs. Terrorist Activity

Discussion: A terrorist disaster is a completely different type of disaster. The scene is both a crime scene and a disaster site, which presents major challenges for a relief agency.

Recommendation: Ensure the disaster plan includes staffing supervisory personnel at the site and at service delivery areas. Plan for supervisory shifts to check in daily with headquarters staff to secure efficiency through sound communications.

Issue #4: Family Assistance Center/Compassion Center

Discussion: The Family Assistance Center (Compassion Center) was a huge component and very successful. Red Cross Family Services focus was to reach all families of the deceased and victims who had been hospitalized or experienced medical problems. Red Cross worked with numerous agencies, one of which included the ME's office to ensure all family members would receive quality care.

Recommendation: It is important for a community to review this ahead of time and plan for the key players to get together and determine roles. If the Red Cross is responsible for opening the site, they will repair any damage to the building used leaving it in better condition than found. It is important to allow the Red Cross to be the player in that process so that in the end the regular tenants of that makeshift center are protected. The FAC needs to involve an integrated team approach using case managers, nurses, mental health professionals and clergy. It should also have a mobile component to go directly to families' homes. Planning should include key players who can provide food, caseworkers, mental health professionals, clergy, vol-

unteers, medical examiner, funeral directors, and security. This plan should be in place prior to a disaster. Again, mock disasters including all agencies involved in a disaster of this magnitude should be involved.

Issue #5: Planning and Training

Discussion: Prior to April 19, 1995, the American Red Cross disaster plans covered natural disasters, which are handled differently from an act of terrorism. Oklahoma City had handled many tornadoes, floods, and fires but the Oklahoma City bombing proved to involve very different issues and, therefore, required much more organization at multiple levels. It also included law enforcement such as FBI in its relationship to handling a crime scene and the emotions of our community as they relate to a man-made disaster.

Recommendation: Plan and train for acts of terrorism. Include multiple site commands and a Family Assistance Center. Be flexible to do what the community needs during a disaster. Keep things comfortable and easy for everyone involved. Educate those who will be preparing for the next disaster. Share information and education so that more people can help. Things will run smoother if there are established roles and chain of command for all areas of disaster response. Training using mock disasters is imperative. Be flexible in your disaster plan so that with each disaster there is room to expand or shrink in areas you need. Remember to focus on the fact that the event is "Not about us, it's about the victims." The non-profit agencies need to be kept in the loop and recognized as the key players too.

Issue #6: Established Relationships

Discussion: One of Oklahoma City's successes was the fact that many of the key players knew each other prior to the event. The Red Cross had access to each of these key individuals and they could be reached at any time.

Recommendation: Establish relationships with key individuals (fire, police, media, other agencies such as United Way, Food Bank, Salvation Army etc.) so that an established trust is already present prior to an event. Include all CEO's of nonprofits so that each can coordinate and plan together prior to an event. It's important to include everyone so that all your local resources are tapped.

Issue #7: Media

Discussion: During the event volunteers would be asked to speak to reporters and would get on camera and say we needed certain items without realizing we may have already received a shipment of those items somewhere else. This created duplication and chaos.

Recommendation: Set forth a thorough media/communications plan within the disaster plan. Filter all communications with the media through one person. Allow only Public Relations staff to speak to media that are trained in crisis PR.

Issue #8: Donations

Discussion: During the disaster, the Red Cross was inundated with donations of goods, services, and funds. The Oklahoma County Chapter was not accustomed to the mass quantities in terms of processing and storing them. We relied heavily on our National Organization.

Recommendation: If possible, the Red Cross needs to assign a consistent full-time employee/employees to handle the influx of mail, in-kind and all other contributions. Staff need to be trained how to accept mail, goods, and services and distribute accordingly.

Issue #9: Mental Health

Discussion: Mental health needs were more important than anyone had anticipated. At every level of the disaster, mental health professionals and counselors were important to help with debriefing.

Recommendation: Align mental health professionals ahead of a disaster. Organize and credential them. Plan to tend to long-term mental health needs. Expect staff turnover following a disaster.

Issue #10: Unmet Needs Committee

Discussion: The number of individuals with needs and the different types of needs was magnanimous. Implementing the Unmet Needs Committee was a necessity.

Recommendation: The Resources Coordinating Committee (RCC) was established and comprised of over 50 agencies. Goodwill was the neutral party in charge. As a member of the RCC, an agency had to have resources that could contribute to the victims. The RCC met weekly for approximately three years and assessed claims brought to the table by caseworkers from churches, nonprofits, civic groups and others.

FACTS:

- Approximately 1,088 psychiatrists and social workers volunteered thousands of hours to victims requiring mental health needs.
- Two Red Cross shelters housed 68 people and more than 340 were placed in temporary housing.
- Over 1,500 people with injuries and health related issues were cared for by registered nurses and other certified medical personnel.

- More than 9,600 Red Cross volunteers and paid staff assisted with relief efforts.
- The Red Cross assisted 1,568 families or individuals in locating loved ones through the Disaster Welfare Inquiry Process.
- St. Luke's Methodist Church, located near the site, became one of the temporary shelters and 177,000 meals were served through the emergency response vehicle at this location.
- The Red Cross Damage Assessment team provided assessments for several dwellings around the area.
- A service center was established at Shepherd Mall and was in operation soon after the bombing and continues to be open today. This center provided a place for family members, survivors and rescue workers to receive assistance. Family members, survivors, rescue workers and others affected by the Oklahoma City bombing also received assistance with long-term medical needs, mental health and counseling, and various miscellaneous living expenses until they could get back on their feet.
- Nearly seven years later, Red Cross has 30 active cases at Sunbridge Mental Health.

## Dave Hockensmith, Jr.

### Military Chaplain, Oklahoma National Guard

Like most people in Oklahoma City, Dave Hockensmith felt the earth shake the morning of April 19. Upon learning what had happened, he immediately went to Baptist Hospital to help. Realizing there were no patients and family members coming to the outlying hospital, he left at noon. He then checked in with the Military offices and was told to stay on standby. At 4:00 p.m., he was called to state active duty at the Oklahoma Military Department and by 8:30 p.m., was deployed with several other chaplains to the Family Assistance Center at the First Christian Church. Because there was no model to follow, the atmosphere was chaotic. There were several agencies there and no one had a sense of who was in charge. Media were in the building, which contributed to the chaos. He remembers several reporters conducting less then appropriate interviews with family members. As the event unfolded, several key players stepped up to the plate to start bringing order to the situation.

Lessons Learned:

Issue #1: Credentialing Clergy

Discussion: There was no process in place to credential volunteering clergy. It is hard to know who was properly trained to help and who wasn't. This issue still hasn't been addressed in Oklahoma City and a designed process to credential clergy has not been established to date. The diverse ways different churches recognize clergy creates a problem. Whether self ordained or highly trained, clergy need to be carefully screened.

Recommendation: A standard for credentialing clergy members could streamline the process. One suggestion is for a church council to set some basic standards and then appropriately identify clergy members prior to a disaster.

Issue #2: Family Assistance Center

Discussion: During the incident, staff of the First Christian Church was outplaced from their offices while the Red Cross established the Family Assistance Center. Early on, there was no set structure or order. Have the plan in place during peace so that when disaster occurs, everyone understands their role and responsibility.

Recommendation: Establish a plan for a FAC and determine who is in charge, whether it is the Red Cross or another entity. Identify and help everyone involved understand their role in the process. When establishing a FAC at a facility, remember to include the existing staff of that facility.

Issue #3: Media

Discussion: While the media play a vital role in providing public information, members of the media should be kept separate from family members unless otherwise specified by family members. Family members should decide if they want to speak to media.

Recommendation: Plan for appropriate security to help control media and keep them at a distance from the FAC. Also provide for escorts to take family members from the center to their cars.

Issue #4: Established Roles

Discussion: The National Guard Military Chaplains really didn't have a clearly defined "role" upon call-up. Military chaplains went with the flow and found ways to be part of the solution. Work with everyone. National Guard Chaplain's roles became that of escort for notification or simply escorts from the family center to the family members' cars. Chaplains would also take turns listening, sharing, and praying with family members. It was helpful to have both the uniform and the cross identified. It was a symbol of security.

Recommendation: Design a plan that utilizes all resources and meet prior to an incident to determine jurisdiction and identify who is responsible for what.

Issue #5: Planning and Preparedness

Discussion: Recognize that no matter how prepared you are, you are never prepared enough.

Recommendation: Get prepared anyway.

Issue #6: Human Element

Discussion: Don't ever hesitate to step in and act as a mediator. In the FAC, some professionals behaved in less than professional ways. As an example, there were turf issues and infighting between psychiatrists, psychologists and social workers. This wasn't the place for that. Cultural awareness is critically important. Different cultures react to loss differently from others and grieve differently. Chaplains/clergy seemed much more culturally aware than some mental health professionals, some of whom, initially, wanted to sedate at the drop of a hat. It is human nature to jump in, run in, save people. It is important to figure out a way to override that natural tendency. Stop, plan, and figure out what is best in the long haul.

Recommendation: Pace yourself and don't try to assume the position of God. Get rest so that you can stay involved for the long haul. Get past self, turfs and egos. Ask yourself "how can we use our God given talents to do good and benefit others?"

## Cathy Keating

### First Lady, State of Oklahoma

On the morning of the April 19, 1995 bombing of the AP Murrah Federal Building, First Lady Cathy Keating was in Tulsa preparing for her move to the Governor's Mansion in Oklahoma City. Her first thought was where the Governor was in correlation to the Federal Building. Once she ascertained where Governor Keating was and that he was safe, she cleared with security to come to Oklahoma City. She arrived in Oklahoma City at 1:30 p.m.

Mrs. Keating quickly identified her role as a liaison to the staff and the community and an advocate for the victims, survivors and family members. She reported to the State Capitol, identified key staff personnel, made certain everyone was okay, and had what they needed. She then went to the site with the Governor and began asking the volunteers and rescuers what they needed. By 9:00 p.m. that evening, she met with the Chief of Police and some key friends and began organizing a national prayer service. She called

Billy Graham's office and scheduled him to lead the prayer service because although it was an Oklahoma tragedy, it was America's loss and she felt strongly that we needed a national name to lead us in prayer.

Lessons Learned:

Issue #1: Mission

Discussion: Mrs. Keating's mission was to focus on the families no matter what. Focus not on self, but on families.

Recommendation: Determine the mission and stick with it.

Issue #2: Funds for Victims

Discussion: Cathy knew the families and their children would need support through the healing process so she decided to put a book together to highlight stories of some of the victims and survivors. She called Random House and asked them donate all proceeds. They in turn went to their vendors to ask for underwriting and they donated their costs.

125,000 copies sold and over $1,000,000 was raised to establish a College Fund for the victims' children.

Recommendation: Make sure if a fund is established for victims, it is in a designated place where the purpose of the fund is carried out. If victims' family members need money, they need to have easy access to it. Establish an Unmet Needs Fund to cover those things that slip through other cracks, with checks and balances to ensure fairness to all.

Issue #3: Continuation of Care for the Community

Discussion: After the bombing, the Governor's office hired a full time staff person to handle calls or issues on a daily basis. This was critical and key to Oklahoma's healing. People always know they have a staff person to talk to and a place to find that person.

Recommendation: Initiate a plan to include a full time staff person with direct reporting to a person able to make immediate decisions.

Issue #4: The Memorial Process

Discussion: The first order of business for Oklahoma City was the National Prayer Service the Sunday after the bombing. The Prayer Service was a huge undertaking and required unions being employed and therefore union rights being waved for the television crews, the Philharmonic, etc. Diversity was critical to the success of the Prayer Service. There were victims from every walk of life and at every age to consider. An important element was the Children's Prayer and although no single age group was to be distinguished, she felt a special prayer for the children was important. The Presi-

dent of the United States decided to be a part of the prayer service. That established another whole set of issues. The Secret Service arrived a few days early to prepare for his visit. There were several issues with the Presidential Staff and Cathy held firm to her beliefs that this was not about the President of the US, it was about the family members. It was equally important to recognize victims, family members and the rescuers who also had families suffering. Symbols of hope such as ribbons, roses, and teddy bears became an important part of the recovery process.

When the Memorial Committee was first formed, the First Lady was asked to be on the committee and she declined. In retrospect, she should have been on the committee so that she could have remained a strong liaison for the committee and understand what was going on in the process.

Recommendation: Recognize the importance of the memorial process in your community. Do whatever it takes to recognize those involved in the process and offer symbols of hope and community support.

Issue #5: Stress Debriefing/Mental Health Needs

Discussion: As a public official, recognize the importance of debriefing at every level. It's critical to the long-term health of the community.

Recommendation: There is a need to establish a National Headquarters of Trainers for Debriefing. One-on-one help is critical to the healing process.

## Frank Keating
### Governor, State of Oklahoma

Governor Keating heard the explosion from his office and immediately walked down the hall to his Director of Communication's office to watch the television. Upon learning what had happened, he first contacted the Highway Patrol to assist, activated the Emergency Management Groups, and declared a verbal state of disaster and sought assistance from the President of the United States.

He then cancelled his scheduled day of activities and reported to the state's Emergency Operations Center (EOC). It was not until later in the day that they realized the EOC, which was built during the cold war, was not allowing cell phones or pagers to operate and he was cut off from external communications. While landline telephone service was not seriously affected, cell phone circuits were soon jammed and virtually inoperable. In addition, the different radio frequencies and systems used by assorted emergency management and public safety agencies made inter-agency communication

difficult. Both of these factors limited the flow of timely information to the EOC. By 3:00 in the afternoon, he decided to go to the site and offer assistance to the rescuers.

Lessons Learned:

Issue #1: Planning and Preparedness

Discussion: Practicing a disaster plan is a key to success. Because Oklahoma City and state agencies charged with public safety and emergency reponse had practiced and prepared for natural disasters, everyone was ready to respond.

Recommendation: Implement a solid citywide plan and endorse disaster drills on a regular basis so communities within your state can respond as though it were second nature.

Issue #2: Established Roles

Discussion: When several agencies must work together, it is important that they have a relationship already in place to minimize turf issues and egos.

Recommendation: Take a proactive approach in aligning first responders from multiple agencies and multiple levels to work together and coordinate cohesive and effective plans. When all the players understand whose role is what, the focus can remain with the task at hand.

Issue #3: Media

Discussion: During the Oklahoma incident, media from around the world came to Oklahoma. It was important to commandeer them and control them to maintain the accuracy of the messages being sent out to the world. The media was restricted to an area far enough to stay out of the way, and close enough to have a visual of the building. As recovery efforts progressed, media would be involved to share stories. Oklahoma used the media to convey important information to the public.

Recommendation: Provide information to the media thoroughly and quickly without a spin on it. Just deliver the facts. Provide frequent press conferences and use your media to curb rumors.

Issue #4: Communication

Discussion: The most important key to the success of the Oklahoma incident was good communication. When you can include the public,
you diminish the opportunity for anger and frustration. During a disastrous event, it is important to keep people informed in a calm and orderly fashion with factual information. If there is no new news to report, tell them that and tell them why. Help them understand what is happening.

Recommendation: Bring information to your families. From construction workers on the cranes, to the FBI, ATF, etc., report to the families so they know what is going on at the site. Establish an effective spokesperson and put them in front of the public early on.

Issue #5: Donations

Discussion: Oklahoma City received an overwhelming number and quantity of donations from all over the nation and around the world. Although initially deposited in a number of different accounts administered by the state, the city and several private charities, these donations were soon brought under a coordinated disbursement and management process that worked well and which continues to assist needy victims in an effective manner seven years later.

Recommendation: Designate United Way or some other agency to administer donations so that a process is established to receive and allocate funds. An outside agency can also instill a process to avoid duplication and overlap for victims and families.

Issue #6: Mental Health and Stress Debriefing

Discussion: To help minimize serious mental health issues, provide rescuers and families with hot meals, flowers, well wishes, notes on their pillows from children, free phone calls and personal thanks from public officials. This also energizes them to do a better job. Offer spiritual counseling as well as secular. Sometimes the only answer is a spiritual one.

Recommendation: Provide appropriate funds and resources to take care of the mental needs of your community. Align the key players to plan for short and long-term needs of the community.

Issue #7: Align Resources

Discussion: In the aftermath, the Governor's office hired a full time employee to take questions and assure response to questions, concerns and needs. The most efficient response is a local one. Keep the dialogue between victims, families, and citizens personal. The way to do that is with a designated person to handle calls and questions. Do not shuffle people to a federal number, etc. During the disaster, the Governor brought in the Graves Registry to assist in getting bodies ready more quickly so family members could get on with funeral services etc. This is critically important to family members. When a loved one dies, it's human nature to want to get to the body as soon as possible. This allowed families to reunite with their loved ones faster.

Recommendation: Utilize the resources you need to get the job done.

Issue #8: Maintain the Human Element

Discussion: Community response to the bombing was unprecedented, but not unanticipated. Oklahomans have always been quick to help a neighbor in trouble, from the old "barn raising" ethic of land run days to more recent natural disasters. Following the bombing, the outpouring of local support and volunteers was heartening and most useful. Offer a prayer service that everyone can be a part of. Our prayer service set the stage and gave everyone a spiritual and patriotic focus. During a disaster, people need a sense of family and community. A prayer service provides that.

Recommendation: Do whatever it takes to take care of people. During tragedy, the only certainty is community.

## Richard M. (Mike) Love, Sr.

### Emergency Management Specialist for Department of Public Works, City of Oklahoma City

Mike Love was in his office located five miles south of downtown Oklahoma City when the Murrah Building was bombed. As his windows rattled, he heard the explosion and he and his boss got into his work truck and headed towards downtown. Love recalled trying to contact supervisors and others within his department, but cell phones were inoperable. Once they arrived at the site, they helped a crane back into place and Love assessed the situation and knew more equipment would be needed. The scene was chaotic and so he decided to start assembling workers and equipment from the Street Division at a staging area within blocks of the site. Through this staging area, he began collecting bulldozers, barricades, and other equipment to utilize throughout the recovery effort.

The first day was completely dedicated to supporting the Oklahoma City Fire Department and the Oklahoma City Police Department by clearing streets, sweeping glass and debris from streets, hauling debris, setting up barricades, traffic management, and lining up heavy equipment.

Lessons Learned:

Issue #1: Established Relationships

Discussion: Mike knew many of the players. The fact that most of the City employees had gone to Emmitsburg,VA, for the mock disaster training was a godsend. The key players such as Fire Chief Marrs and John Clark with the OCPD already knew their roles and what needed to be done.

When FEMA and federal agencies arrived on the scene they were forced to allow the local agencies to maintain control. FEMA recognized that they didn't have all the answers or the experience and they learned a lot from our local agencies

Recommendation: It is important to establish relationships with other agencies at various levels of jurisdiction so that if disaster occurs, the players already have a rapport with each other and at the very least, know who to call and when. It is smart to have a list of resource names and contact information within the disaster plan. Further, it's important to train those under you so that in your absence they are ready to step up and take charge.

Issue #2: Planning and Preparedness

Discussion: Even though there was no updated city plan at the time of the bombing, there was a plan. Many of the city's employees had begun rewriting the plan to reflect lessons learned in Emmitsburg. Again, the training in Emmitsburg galvanized the roles everyone took. Everyone knew what to do and most did so without the mandate from a supervisor simply because there was no way to communicate with supervisors. Remind yourself as a City employee that life does go on beyond a disaster. People still need water, trash service, and protection from crime and fire. Utilize your mutual aid agencies from surrounding communities to assist in continuing day-to-day activities for the city and make certain the plan outlines that.

Recommendation: Invest the appropriate time and dollars for proper planning and coordination of efforts between every level of response and at every level within the department. Align resources and practice until every aspect of the plan becomes second nature. Make certain all employees understand their roles and what is expected of them. Try to learn something new every day. The world is ever changing and terrorism is here to stay. Be ready and be flexible.

Issue #3: Communication:

Discussion: In the initial hours of the response, telephone lines were nonexistent and cell phones were inoperable due to the large volume of calls. Additionally, two-way radios were cutting out because everyone was resorting to two-way radio communication. Communication is vital to orchestrate who is handling what. After the first day, Oklahoma City was able to establish priority lines on cell phones for everyone to communicate. To do this on a regular basis is cost prohibitive.

Recommendation: In the first hours of a disaster, plan to use walkie-talkies among departments so that at least departments have lines of communication with each other. Then plan to secure priority cell phone lines, but recognize that those take up to 24 hours to set up. The first hours are really important so recognize and plan for that.

Issue #4: The Importance of Shifts

Discussion: In the first days of the Oklahoma City incident, adrenaline was at an all-time high. Once the adrenaline stops, the body cannot properly function. Mike worked 24 straight hours the first day and then nearly collapsed. His team finally started rotating shifts in an effort to rest and recover.

Recommendation: Properly plan for several shifts of workers to rotate in during a disaster. Bear in mind that the day-to-day functions of the community such as trash collection, etc., have to keep functioning. Schedule enough personnel to tend to the needs of a disaster and still have enough crew to cover the city's daily services.

Issue #5: Human Element

Discussion: In every step of the process of the recovery effort, the city tried to concentrate on people. If you take care of people, the task at hand takes care of itself. The Oklahoma City bombing forced the community to work together under the worst of circumstances. Through properly taking care of staff and people, the community was able to endure the task at hand.

Recommendation: A good disaster plan needs to address all needs of all people. Whatever it takes, do it.

## Dan Mahoney

### Director of Communications, Office of the Governor

From Dan's office in the State Capitol, it was not possible to hear the explosion that happened at 9:02 a.m., Wednesday, April 19, 1995. Dan first heard about the bombing from the radio, which is normally not on past 8:30 a.m. He noticed the tone in the announcer's voice and knew immediately something was not right. Within minutes, the Governor, who did hear the explosion from his office on the opposite end of the State Capitol, came to Dan's office to see the television. Together they watched the live coverage from the local news station's helicopter camera.

The Governor had an important trip to Dallas scheduled. The staff agreed to cancel that trip. The staff needed to determine the Governor's role in the bombing. Because the Governor's background was Law Enforcement and FBI, the Governor wanted to gather experts to determine what needed to be done from the State's point of view.

The Governor's office contacted President Clinton and learned that FEMA had been deployed. The Governor then conducted a press briefing at 10:30 a.m. to let the public know that we did not have all the answers, but that things were being handled and they need not worry.

The Governor's office determined they needed to place the Governor in the Emergency Operations Center at the State Capitol complex to keep him safe and to allow him the time to meet with key personnel to ascertain plans. The staff made a concerted effort not to go to the site. At that point, the State Capitol was closed and employees were sent home. At 3:00 that afternoon, the Governor went to the site to offer support to the rescuers.

Lessons Learned:

Issue #1: Communication

Discussion: Early in the process, the Governor asked the Medical Examiner to report daily to the families regardless of whether there was information to bring them or not. It is important to talk to the families early on and on a regular basis. At first the Medical Examiner and Fire Chief didn't want to report to families until there was news. They later realized it was critical for the families to hear anything as opposed to sitting and waiting.

Early on the Governor quoted numbers of the death toll from figures he had received from a rescuer. The information was not accurate. From that point on, policy was set that the Governor wouldn't discuss numbers and if he did, the information could ONLY come from Chief Marrs, the incident commander.

Recommendation: Establish an individual to report to families on a regular basis. Know ahead of time who it is and then ensure information is accurate and timely. Recognize that the more people know, the more supportive they will be.

Issue #2: Planning and Training

Discussion: When the bombing occurred, the Governor and staff had only been in office three months. It would have been helpful to have gone through the disaster preparedness training prior to the event.

Recommendation: Understand and know the formal flow of emergency management ahead of time. Know the difference between state and federal declarations. Meet your local FEMA reps and your state emergency preparedness staff ahead of time. Familiarize yourself with grant options.

Issue #3: Public Role

Discussion: The Governor was excellent at lending support and sharing grief with the public and yet at the same time was strong and encouraging. He did an excellent job of identifying and commending Oklahoma volunteerism and heroism early on. This strengthened the community spirit and provided a cohesive rallying of the people.

Recommendation: Identify your key leadership for the public early. Identify the best public speaker and provide regular and timely reports to the public.

Issue #4: Pace Yourself

Discussion: Early in the incident you get caught up in the adrenaline and will want to work 24 hours a day. It is important to pace yourself and allow for down time and time to rest in an effort to prepare for the long haul.

Recommendation: Take care of yourself so you can take care of others. Remember your personal life. Remember to always conduct yourself selflessly. This is never about personal agendas.

Issue #5: Utilize Resources

Discussion: In retrospect, the Governor's staff would have incorporated the Internet more to release information. Due to oversight, several staff members were not used to their full potential.

Recommendation: Recognize you have staff and empower them. Delegate where appropriate. Avoid trying to do everything. Recognize those you can count on, who can handle stress, who can't and who uses common sense.

Issue #6: Established Relationships

Discussion: During an incident, you will need to contact people you never thought you would. There is little time to think and less time to backtrack and look for phone numbers. Precious time can be wasted tracking down appropriate contacts and numbers.

Recommendation: Know your resources ahead of time. Know who the public information officers of the fire department, police department, FBI, media, etc. are before an incident. Have all the key personnel identified with cell phone and pager numbers listed.

Issue #7: Media

Discussion: Don't allow yourself to get caught up in the "national media." Always remember your local media. They are there for you before, during and after. National media are not. During the National Prayer Service, family members and media shared the same entrance. In retrospect, the media should have an entirely different entrance separate from family members. However, family members should be allowed access to media IF they want.

Recommendation: Establish boundaries with the media early on and stick to your guns. Most media will be cooperative and understand your decisions. At the first anniversary, boundaries and limitations were set early on with the

media with regard to their "tower antennas, cranes, buckets etc. Set the ground rules and be firm. Do not get caught up in the glamour of the national media personnel.

Issue #8: Stress Debriefing

Discussion: Recognize the human element involved in a disaster. It effects everyone on some level and everyone needs to talk about it.

Recommendation: Stress Debriefing is critical. Offer it early on and offer it over the long haul.

## Gary Marrs

### Chief, Oklahoma City Fire Department and Assistant Chief Kenneth Bunch

Chief Gary Marrs was at the Mayor's Annual Prayer Breakfast on the morning of April 19, 1995. Assistant Chief Bunch was at the station located a few blocks west of the Murrah Building. Chief Marrs had left the breakfast and was headed to a meeting at City Hall when the explosion occurred at the AP Murrah Federal Building. He entered the scene on the east side of the building, which allowed him to survey the extent of the construction and he was able to ascertain that the recovery effort would include several other buildings in addition to the Murrah Building. Other buildings destroyed or damaged included the Journal Record Building, the YMCA, the Water Resources Board Building and the Athenian.

One of the first challenges was the walking wounded. They were stopping fire vehicles that were headed to the scene and the first responders had to help the walking wounded before they could even get to the site.

The second challenge was gaining control of the entire area to triage patients. There was litter in the streets, it was chaotic, and it was very difficult to account for who was in the building and those going into the building to help victims. We had a huge fear the building would collapse and we had hundreds in the building and several hundred others trying to help those in the building.

Upon arrival at the scene, the fire department had already established its incident command post. Fire Chief Marrs, Police Chief Gonzales, FBI Special Agent Bob Ricks, and Mayor Ron Norick met to determine and define roles. This meeting set the tone for the entire incident and became known as the "Oklahoma Standard."

- Chief Marrs, Fire Department - In charge of rescue and recovery
- Chief Gonzales, OCPD - In charge of security and perimeter control
- Special Agent in Charge Ricks, FBI - In charge of the crime scene

- Mayor Norick, OKC - Handle the local media

Each knew his role and they cooperated with each other so that when the State and Federal personnel came on site, the process that was successfully working was continued.

At 10:30 a.m., a potential second bomb was sighted and the building was evacuated. This was a blessing because it allowed us to gain control of the building and set up a controlled coordinated effort.

Once a controlled plan for search and rescue could be implemented, the fire fighters were frustrated because they couldn't all go in at one time to help. Teams were identified and rotated in shifts.

FAMILY ASSISTANCE CENTER

The fire department and the Red Cross in Oklahoma City have a long-standing relationship, which proved to be a huge benefit to our efforts. Early in the morning, the Red Cross came to Chief Marrs and asked how they could help and Chief Marrs asked them to set up the Family Assistance Center in an effort to take the burden off the fire department of answering to the families. Additionally, this gave the Medical Examiner a place to get his information and notify families.

The agreement was as follows:

- The fire department would release numbers, but not names
- The Medical Examiner would release names, but not numbers

The key elements that made the FAC successful were:

- Secured facility
- No media
- Away from the site, yet information was given to the families in a timely fashion

Lessons Learned:

Issue #1: Communications Between Agencies

Discussion A: The first day of the incident communications between response agencies was difficult. Standard and cellular phone circuits were overloaded. Two-way radios proved to be the most efficient and reliable way to communicate during the first few hours of the bombing. However, the Oklahoma City Police Department switched their communications to a common police channel, which enabled them to communicate internally, but isolated them from other agencies.

Standard/Cell phone problem: The phone service providers refuse to grant any "priority" service to emergency agencies.

Recommendation: Establish a "Preparedness Council" comprised of top-level management from state government, federal agencies, and local area responders, hospitals and media. Establish a directory of cellular telephone numbers of key personnel and configure a trunking system to provide priority service to these numbers.

Standard/Cell phone solution: Lobby the FCC or Congress for "priority override" for phone services for public safety agencies since none of the phone services will provide this of their own volition.

Discussion B: Responding agencies, whether local, state, or federal, had different terminology and protocol for emergency/disaster response. This was confusing and frustrating for the different agencies and caused slower response due to backtracking and coordinating.

Recommendations: Standardize a common clear text language between agencies so everyone understands procedure and flow. Avoid acronyms and codes with which no one is familiar. Local, state, and federal agencies need to plan and practice an Integrated Emergency Management System (IEMS) that all are committed to and refer to in the same terminology.

Issue #2 Incident Command Operations

Discussion: There was a minimum of seven mobile command posts representing various agencies coordinating numerous support functions. The Oklahoma City Fire Chief maintained command, though, there was initial confusion and fragmentation. Often there were duplications in requests and delayed action while the different incident commanders checked with each other.

Recommendations: The local community leaders are the ones who manage the incident. The State and Federal agencies are there to assist. When mapping out a disaster plan, practice that plan and align all key agencies, the rest will take care of itself.

- City, State, and Federal agencies need to communicate and practice response plans to include establishing one incident commander. All resources for the incident should be channeled through the IC. When the IC requires resources from outside his jurisdiction, he should direct requests to state and federal levels.
- Have a resource listing of city vendors and alternate sources for items needed.
- Make provisions for adequate staff to document invoices, purchases, loaned equipment and tools.

- Align partners in the field, such as USAR teams, with partners in the command posts to talk to each other. (For example, if USAR teams are working with firefighters at the scene and they have an issue, make sure there are liaisons at the command post to work out those differences and secure a voice for both sides of the team.) "They won't let us use their tools. They won't let us in a certain area and you said that's where we should search."

Issue #3: Established Relationships

Discussion: The Chief of Police, the Chief of the Fire Department and the head of the FBI were personal friends prior to the bombing. Each respected each other and their defined roles.

Recommendation: Establish key relationships with the key players prior to an incident. This was key to the communications/turf/ego issues. When these relationships are established prior to an event, the players can establish a response system based on trust and mutual respect so that when the federal, state, and county officials arrive, a well-defined system is in place. Interface the crime scene and the response area. Work together and complement each other's efforts to avoid additional problems. Use common sense in your approach to things. Don't alienate people, but don't allow people to get in the way either. Share command, set boundaries and focus on the job in front of you. It is important to have ongoing multi-agency drills to accommodate new issues and new staff.

Issue #4: Training

Recommendations: Training is critical to the process. If everyone is trained in their roles, then it becomes a way of doing business and the incident commander can do his job instead of trying to coordinate all the other players. Train with outside agencies more than once a year so that working together becomes second nature.

Issue #5: Staff Morale

Discussion: Throughout the 17-day response effort, several key issues relating to staff morale surfaced. Many of the problems could have been avoided through a common sense approach.

Recommendations:

1. Establish a plan ahead of time that addresses staff rotation. If outside agencies are used, make sure your own staff has an opportunity to work the scene too. Rotate rescue workers in shifts and allow everyone an opportunity to help. There are those trained for key areas, but allow others to be involved so they feel they have done their part too. This not only helps morale, but it helps pace teams so no one is overburdened.

2. Shifts need to be unified between all other agencies when working side by side. If USAR teams have 12-hour shifts, fire department and police need to have the same 12-hour shifts for continuity.

3. There needs to be a system for feedback as staff are working the scene so commanders can be responsive to their needs. If you are organizing a certain way from the command post and something else is actually happening on site, make sure there is a way for that feedback to be heard so that you can adjust your plan accordingly. (Everyone was given 4-hour shifts on the site, but many were waiting to be processed for three of those four hours so they were actually only working one hour on the site.)

4. Offer periodic briefings between the different fire commands. Each of the separate jurisdictions within the fire department needed to understand what the other was doing. It helps them understand the bigger picture.

5. Utilize senior officers in appropriate positions. Assign ALL of them so they ALL gain experience. It also helps morale, while offering first hand training.

Issue #6: Media

Discussion: In the initial phases of the response effort, local media were directly on the site. This caused chaos, as they would hear responders shout out commands or requests and would interpret the requests as items needed at the site. This created more chaos, as individuals would deliver items they had heard broadcast and sought to bring them to the site.

Recommendation: Restrict media from the site, but accommodate them. Utilize public information officers from Police/Fire/FBI to establish a boundary for the media and contain them. Keep them far enough away from the site, yet close enough so they have a visual of the building. Take firefighters and their stories to the media. Align your media as your ally so they will work with you to take care of the effort and the community. Contain them in a secure, remote location so that you can utilize them to inform your public, as you need the public informed.

A critical successful step taken was asking the media to select a key representative from each of the media areas. Those few personnel were taken to the site and allowed to see what the recovery effort was all about and then shared their film with all of the press. We restricted them from shooting photos of bodies, but we helped them understand the magnitude of the situation which we were in. This was key to our process because they then became our allies and could understand our perspective and the obstacles we were trying to overcome.

Issue #7: Donations

Discussion: During the initial response, people were dropping off supplies, equipment, food, etc. next to the command post and it caused chaos at the scene. These items were not checked through a security checkpoint nor were they appropriately documented and accounted for. Food services arrived within the perimeter, which led to unsanitary conditions.

Recommendations: Establish an outside perimeter for donations. Implement a Unified Donations Management Plan to appropriately manage and acknowledge donations. Have one clearinghouse of purchasing, receiving, ordering etc., to avoid overlap. Make certain there are enough staff available to process donations. Utilize resources such as the State Health Department to set up and screen food operations near recovery efforts.

Issue #8: Spontaneous Volunteers

Discussion: It is part of the human spirit to want to be involved and help. The volume of spontaneous volunteers from outlying metro area fire departments, as well as those from all over the country, was overwhelming. IC must maintain control at all times and the act of "self dispatching" without being requested creates more chaos.

Recommendations: It is important to align with Metro area agencies so that other agencies can assume some of the roles that are exterior to the incident command. Involve volunteers, but do not disengage your own departments. Establish a healthy formula for rotating local staff with outside agency volunteer staff. It is important that all outside agencies report to the incident commander to be assigned roles. If agencies/volunteers are not requested, they need to understand they will be turned away.

Issue #9: Mental Health/Stress Debriefing

Discussion: The emotional and mental toll a major Mass Casualty Incident (MCI) takes on rescuers cannot be emphasized enough. Even though rescue workers are trained to handle trauma, a disaster such as this one offers experiences no one is prepared for.

Recommendation: Set up a debriefing area on site so that every rescue worker can rotate through a debriefing process before leaving the perimeter. At the close of an incident, allow firefighters an opportunity to process the event and then offer debriefing sessions to all firefighters, their families and top officers. Allow for long-term mental health for firefighters. Make the process easy, anonymous and approachable.

Issue #10: Family Assistance Center

Discussion: During an incident of this magnitude, a Family Assistance Center is a critical component. Families need a place they can be to find out information and hear directly from first responder representatives. At the time of

the Oklahoma City bombing, there had not been designated roles for a Family Assistance Center or a chain of command established. Several different agencies began setting up centers simultaneously, which led to mass confusion for family members who heard conflicting reports on where to report.

Recommendation: The Family Assistance Center needs to be addressed in a citywide disaster plan. There are several different players involved such as Medical Examiner, Funeral Directors, Clergy, Mental Health, Red Cross, etc. They all need to get together and determine roles and establish a chain of command. Since every incident is different, it needs to be adaptable.

Issue #11: Identification of Volunteers and Rescue Workers

Discussion: There was no established registration of ID badges at the site. Initially the FBI began processing and registering ID's. Over several days, over 28,000 ID's were issued and the process became too labor intensive. Originally the badges were color-coded for security measures, but that also caused confusion from day-to-day.

Recommendation: A unified ID system is important. Cities need to address this issue in drills and training. Passport ID systems should be initiated.

## Annette Murphy

### Assistant Principal, Rockwood Elementary School
### Oklahoma City Public Schools

Annette served as Assistant Principal at Rockwood Elementary School located approximately 6 miles from the Murrah Building. Her supervisor was downtown at a meeting at the Administration Building of Oklahoma City Public Schools located about one mile from the bombing. Because most of the elementary principals within the district's 60 plus elementary schools were attending that meeting, they were able to develop a quick strategy for each of the public schools. Secondary schools were notified of plans by fax and calls from the school district's top administrators.

Annette's principal called her and notified her that the school building was to be locked down as a safety precaution. She was also informed that schools would remain open in order to help maintain a sense of calm and normalcy.

All district teachers were asked to ascertain which students had parents in the Murrah Building. Students were kept at their schools until relatives picked them up or were taken to one specified elementary school in the district until family members could come to take care of them.

Over 800 students throughout the 40,000-student district had family in the building or were directly affected by the bombing in some way. Recognizing the impact on the entire public school system, schools officials secured a

grant through FEMA to begin a counseling program. An initial planning grant was funded for the summer after the bombing and the counseling program, Project Heartland Recovery Counseling, was fully funded by November, about seven months after the bombing.

Annette was appointed head of the counseling program. A steering committee of community leaders in the psychological field was formed to assist in developing plans for the program. Approximately 20 counselors, 10 community liaisons and several interns, who worked directly under the counselors, were part of the Project Heartland Recovery Counseling. Because of the large Hispanic and Vietnamese population within the district, bilingual liaisons were available as well.

The counselors met with principals and were assigned to schools based on ethnic background, time available, and age appropriate counselor assignment. The counseling grant provided counseling services for 13 months and then was extended for five additional months. The primary resource for the project was Marleen Wong from Los Angeles recommended by the US Department of Education Safe and Drug Free Schools Division.

Lessons Learned:

Issue #1: Planning, Preparedness, and Established Relationships

Discussion: The Public school's disaster plan primarily included plans for a natural disaster for each independent school. There were no provisions for communications between schools. Further, public school officials had not established a disaster plan that included communications with the police, fire department and others regarding response coordinated efforts toward the recovery effort. Due to this fact, a considerable amount of time was spent tracking down contacts and resources. Had those relationships been in place prior to the event, there would have been less chaos and confusion.

Recommendations: Public school systems need to coordinate with police, fire department and media prior to a disaster to secure an appropriate and coordinated plan. Appropriate steps and protocol should be outlined and roles assigned and practiced. Through careful and thoughtful planning, the necessary steps taken become second nature and minimize chaos and confusion. Practice is critical to the process to ensure administrators remain calm. Because children look to leaders for role models, it is important to mirror a calm, cool, collected stature.

Issue #2: Media

Discussion: During the aftermath of the bombing, media personnel were arriving on the steps of schools asking for interviews with teachers and children. This created more chaos for the children and was disruptive to daily activities.

Recommendations: Incorporate a media policy that addresses all aspects of an incident with regard to on-site interviews with staff and students. Designate an official public information officer to route all media calls first. Require media to follow appropriate channels of communication and secure parental approval before granting interviews. Once a sound media policy is in place, ensure all administrators and staff have a clear understanding of the policy.

Issue #3: Mental Health

Discussion: Within days of the bombing, hundreds of mental health professionals from all over the country were contacting public school officials to help. Many just showed up. It took additional hours to process these volunteers and check credentials. To further add to the chaos, several mental health professionals were requesting permission to conduct research studies on the student population, which can become terribly disruptive.

Recommendations: Mental health professionals and outside agencies will want to help. Channel them through a steering committee to minimize chaos. Additionally, set up an appropriate process to credential these professionals in a timely manner. Utilize a steering committee to screen agencies wanting to conduct studies. The Oklahoma City Public Schools limited studies to one local university. Because some administrators do not understand the importance of mental health interventions, orchestrate conversations before an event so that mental health needs are identified up front and provisions are made accordingly. Recognize that a disaster is not just about loss of life, it's also about loss of jobs. There are injuries and people are displaced and there is a larger emotional element than the obvious picture. Educate parents about the importance of limiting television viewing during a disaster. The disturbing scenes and repeat reports can add stress to children who may not be able to differentiate that the repeat reports are the same event.

Issue #4: Donations

Discussion: Massive numbers of letters, cards, teddy bears, etc., arrived from all over the world. While these are comforting, too many can pose a problem.

Recommendations: Establish a plan for a clearinghouse for all well wishes and gifts. When possible, limit letters and teddy bears, etc. One letter from an entire school is sufficient.

## Mike Murphy
### Field Supervisor
### EMSA

The morning of the explosion, Mike was in the EMSA building, approximately 5 blocks away from the explosion. He felt the explosion and ceiling tiles fell around him. He initially thought it was a gas bomb in his own building. There had been arson the week before and he thought the same individual had just bombed their building. When he looked outside and saw the smoke, he and a group of technicians from an advanced cardiac life support class took three ambulance units to the site.

They first attempted to set up a triage area one block from the site on the north side of the building. At the same time, EMSA units from the south side offices were coming from the opposite direction. He checked in with the fire incident command and planned to be the liaison with them. He originally assigned a co-worker to run the triage area, but the co-worker requested assistance so Mike spearheaded the medical command triage area and assigned a new liaison with the fire incident command.

The initial game plan was to get all the wounded to a common triage area at Sixth and Robinson. Because of the lack of communication, triage areas were being duplicated on either sides of the bombed building. When Mike realized a second triage area had been set up, he sent runners to communicate with them. The runners, however, were not returning with the needed information.

Lessons Learned:

Issue #1: Planning and Preparedness

Discussion: Emergency Medical Responders are taught to concentrate all patients in one area and ascertain an overall view. In an urban setting it is not easy to consolidate the wounded. Those walking and being transported by civilians do not know to check in with a centralized location.

Recommendation: Allow flexibility in the plan to set up multiple triage areas, but coordinate efforts and communications. In July 1999, the Medical Management Response System (MMRS) was established to address the trouble spots and try to create solutions to maximize a coordinated effort for future events. MMRS included hospital council, FBI, Emergency Management, Police, fire department, EMSA, City and County Health department, physicians, Red Cross, and VA. The result of MMRS was to develop a communications center located at EMSA. The committee is currently addressing standardized codes for all hospitals, decontamination procedures and communication between organizations.

Issue #2: Communications

Discussion: Responders in Oklahoma City were not able to communicate with any of the hospitals and had a difficult time coordinating the flow of patients. It was also unclear which hospitals were available for critical patients. EMSA's regular UHF system was not operable within the EMSA facility and communication could only operate from individual ambulance units.

Recommendation: An effective communications system is critical. Establish a Medical Emergency Response Communications Center so that all hospitals can communicate through a central communications point. This allows responders to assign and divert patients to appropriate hospitals throughout the metro area.

Issue #3: Spontaneous Volunteers

Discussion: Due to media broadcast, great numbers of medical volunteers presented themselves at the scene. Because there were too many volunteers to be screened and assigned in a timely fashion, many became impatient and left the scene. When they returned later, they had to begin the processing over again. Too many volunteers resulted in a bottleneck of processing. Additionally, some volunteers tried to start their own triage areas.

An additional problem was non-local ambulances responding to the scene. The non-local ambulance services did not use the same frequency as EMSA, which caused a lack of communication.

Recommendation: Stage volunteer responders to contained areas. Plan for volunteers. Utilize resources through local hospitals to credential and assign doctors during an event. Oklahoma City responders are working on a prototype of an identification device to hang in the ambulance identifying their clearance into the area.

Issue #4: Resources

Discussion: Local police instantly arrived on the scene and began clearing pathways for ambulances. This proved to be a major effort in the responders favor.

Recommendation: Educate the police to cordon off the area so that credentialed medical professionals are the only ones allowed in the area. Utilize the police to clear areas for traffic flow for ambulances in and out of the area.

Issue #5: Media

Discussion: In April 1995, EMSA did not have a staffed public information officer. A staffed public information officer could have utilized the media to help identify where those injured needed to go for help.

Recommendation: Do not be afraid to use the local media to direct the public to certain hospitals based on care needed. This can help divert people away from the busiest hospitals. Educate your community regarding the importance of staying put until called to help. The broadcast media inappropriately alerted all doctors and nurses to report to the site. This caused mass confusion and chaos.

TOO MANY VOLUNTEERS (MEDIA)

Issue #6: Stress Debriefing

Discussion: Critical Incident Stress Debriefing was made available one hour into the incident. It was not mandatory.

Recommendation: Remember that everyone does not grieve or handle stress the same. Plan for stress debriefing and be flexible to offer different options for staff.

Issue #7: Patient Privacy vs. Public Information

Discussion: During the Oklahoma City bombing, several area hospitals had conflicting policies with regard to releasing patient information to family members and media. This created chaos for members of the community wanting information on victims.

Recommendation: The Health Insurance Portability and Accountability Act was signed into law in 1996. This legislation goes into effect October 2002. This will require the implementation of measures to standardize electronic transactions in health care while protecting the security and privacy of patient health information used or disclosed in any medium including oral communication. This creates a new set of issues for communities to disseminate during a disaster. There is a delicate balance between sharing information with those who need to know versus the general public. A possible recommendation is to disseminate information through the Disaster Welfare Inquiry via the Red Cross as well as establish a Joint Information Center (JIC). Families, law enforcement, and responders can then access information from the Red Cross and media can access information from the JIC.

## Ron Norick

### Mayor, City of Oklahoma City

The Mayor had just returned to his office at 8:30 a.m. after the Annual Prayer Breakfast at the Myriad. At 9:02 a.m., he felt the explosion from his office approximately 7 miles away. His first thought was a sonic boom test. When he finally looked outside and saw the plume of smoke, he called his office at City Hall and spoke with his secretary. She reported several windows had been knocked out at that office and was trying to figure out what

had happened. Mayor Norick turned on the television and began watching the live coverage from Channel 9's helicopter. He decided his best bet was to stay put and not become part of the problem of congestion, etc. He immediately began screening media phone calls at his business office and instructed the media to encourage people to stay put and not go to the site. At 9:45 a.m., he determined it would be best to go to the site and asked the police to come and get him so his vehicle wouldn't be in the way. Upon arrival at the scene, he met with the Chief of the Fire Department, Chief of Police, and FBI to determine roles and divide duties. His first responsibility was to contact the governor's office and ask for assistance from the National Guard to secure the perimeter of the area.

The Mayor began organizing a press conference for that afternoon at 3:00 at the Civic Center. From that point on, they determined there would be two press conferences a day at the Civic Center. He also orchestrated public works, barricades for the perimeter, trash bins for trash, port-a-potties, etc., and began setting up places for the USAR teams to stay during their assistance. His main role throughout the incident was to be available for support to the rescue effort and serve as a resource. He also thanked volunteers, rescuers and so forth on behalf of the city.

Lessons Learned:

Issue #1: Established Roles

Discussion: Local responders set the tone early on. The tone was calm, cool and collected due to the preparedness of the individuals. Once the State and Federal agencies started arriving on the scene, they were there to assist because local responders already had control of the situation.

Recommendation: Establish key players' roles early on and assign responsibilities so there are no disagreements. Leave egos and personal agendas aside.

Issue #2: Media

Discussion: If you do not organize and control information to the press, they'll create stories. Establish who tells the press what (e.g., Fire reported casualties, recovery, etc., FBI reported criminal investigation.)

Recommendation: Give the press the information on a timely and regular basis. Allow them access to public figures.

Issue #4: Communication

Discussion: Communications were a major problem internally for each agency, as well as externally among agencies. Critical decisions and conversations need to take place in the first hours of an incident. Responders relied on cell phones, which were overloaded most of the time. The only option was runners, which slowed down the communication process.

Recommendation: Establish effective communications systems prior to an event. Our city is still working towards funding an 800 MHz system to handle a massive incident.

Issue #5: Donations

Discussion: Money was donated and sent to several different agencies. Officials within each agency struggled with how the money should be allocated, who needed it most, and how to access those people. Community leaders finally deposited all the money into the Community Foundation and asked them to create a methodology for the allocation of the funds.

Recommendation: Coordinate all monetary donations through one source and determine the source prior to a disaster.

Issue #6: Planning and Preparedness

Discussion: All of the city's key personnel had participated in a disaster drill in 1994 in Emmitsville, MA. This drill provided practice for key personnel and enabled them to make decisions and coordinate efforts efficiently. Although the disaster drill didn't accommodate multi-levels of agencies, it galvanized the relationships at the local level and provided planning and preparedness that was critical during the bombing recovery.

Recommendation: Take the time to implement a diverse and comprehensive disaster plan and then practice it over and over so everyone is comfortable with their role.

Issue #7: Established Relationships

Discussion: The Chief of Police, the Chief of the Fire Department and the head of the FBI were personal friends prior to the bombing. Each respected each other and their defined roles.

Recommendation: Establish key relationships with the key players prior to an incident. This was key to the communications/turf/ego issues. When these relationships are established prior to an event, the players can establish a response system based on trust and mutual respect so that when the Federal, State, and County officials arrive, a well-defined system is in place. Interface the crime scene and the response area. Work together and complement each other's efforts. Both are important to resolve problems. Use common sense in your approach to things. Don't alienate people, but don't allow people to get in the

way either. Share command, set boundaries and focus on the job in front of you. It is important to have ongoing multi-agency drills to accommodate new issues and new staff.

## Betty Pfefferbaum, M.D, J.D

### Chair, Department of Psychiatry and Behavioral Sciences, University of Oklahoma Health Sciences Center

Dr. Pfefferbaum was teaching a class in an underground classroom at a nearby private university when the bombing occurred. She did not feel or hear the explosion. Upon learning what had happened, she drove back to her office at the University of Oklahoma Health Sciences Center located northeast of the AP Murrah Federal Building. Within her building there was confusion and most employees were assisting in canceling daily activities for the Department of Psychiatry.

By mid-afternoon her building was evacuated and she remembers feeling distressed by the lack of attention to the evacuation procedures. Many appeared to dismiss the seriousness of the evacuation.

Mental health professionals throughout the community began assisting with the response on the day of the incident. While some of her colleagues reported immediately to the site, she chose to stay at her office, take calls, and assist from there. She later reported to the Children's Hospital to help discharge patients to make room for victims from the disaster. Others helped man telephone hot lines, which Dr. Pfefferbaum said were essential, particularly for the children who had learned about the incident while at home alone.

In the days that followed, the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration provided guidance in developing and implementing a plan to address the mental health needs of the community. A network of providers, organized under the Department of Mental Health and Substance Abuse Services (DMHSAS), established the federally funded Project Heartland. As a member of the DMHSAS board at the time, Dr. Pfefferbaum had an active role in the organization of services.

Project Heartland placed heavy emphasis on emotional support for direct victims and on community outreach. The federal mental health approach to disasters developed out of years of work with numerous natural and man-made disasters and was adapted to address the specific needs associated with this major terrorist incident. Dr. Pfefferbaum believes the federal plan is being further revised to address the specific concerns raised by terrorism and that preparedness activities should be implemented nationwide to address the mental health consequences of terrorism.

Dr. Pfefferbaum recognized the establishment of Project Heartland as one of the most significant activities after the incident. Project Heartland counseled hundreds of victims over a five-year period and worked very closely with the public schools as well as the victims and rescue workers in the community. Project Heartland was a collaborative effort involving a number of state and local agencies and was instrumental in helping the community through the federal trials and the devastating tornadoes of 1999.

Following the Oklahoma City bombing, the Department of Mental Health and Substance Abuse Services, along with local and state agencies, addressed the need for a written disaster plan. Subsequent events in Oklahoma have demonstrated that the mental health community is well rehearsed in its response.

Lessons Learned:

Issue #1: Planning and Preparedness

Discussion: In April 1995, the Oklahoma mental health community had no written disaster plan in place. The Department of Mental Health and Substance Abuse Services immediately developed a plan that included local professionals and agencies. Fortunately, already established relationships made that plan easier to implement.

Recommendation: Develop a plan specific to acts of terrorism. Focus on preparation immediately. Adapt the current federal disaster mental health approach to address the complexity of terrorism. Plan for a long-term approach to mental health consequences. Urge communities to begin preparedness activities now reaching children through schools and adults through community agencies. Develop networks within the states to identify and assign roles and functions in the event of future incidents.

Issue #2: Establish Relationships and Networks for a Multi-disciplinary Approach

Discussion: The Oklahoma City bombing occurred at a time when the Oklahoma mental health community had no written, practiced disaster plan. Thankfully, there was an excellent infrastructure already in place throughout Oklahoma, and the established relationships and networks within that structure fostered collaboration.

Recommendation: Develop strong networks among mental health professionals and meet on a regular basis to organize a plan for terrorist events. It is essential to collaborate with first responders, religious leadership, and other groups that can assist in a multi-disciplinary approach.

Issue #3: Pay Attention to Cultures and Special Populations

Discussion: Different cultures and populations react and grieve differently in catastrophic situations. It is important to honor cultures and whenever possible adapt clinical and research protocols to ensure appropriate treatment.

Recommendation: Mental health professionals need to recognize and learn about various cultures as well as refine their skills and treatment approaches to address the special needs of various populations.

Issue #4: Constantly Refine Skills

Discussion: The mental health community recognizes there are various methods and approaches for treating mental illness.

Recommendation: Specialized novel treatments should be evaluated before widespread use among victims.

Issue #5: Spontaneous Volunteers

Discussion: Immediately after the bombing, volunteer mental health professionals appeared on the scene. In fact, professionals traveled from across the country to provide assistance. This was a mixed blessing. The primary focus in the first hours after a disaster should be on recovery and physical safety. It was difficult to organize, coordinate and assign work. There should also be a process to verify the training and credentials of volunteers.

Recommendation: Ensure the community-wide disaster plan sets forth the infrastructure to develop a multi-disciplinary approach. Encourage the mental health professional community to register as volunteers through appropriate channels. Engage highly trained professionals at the core of the plan.

Issue #6: Documentation

Discussion: It is very important to carefully document what happens during a disaster. Information is key to understanding the reactions of victims and communities. Confidentiality is also important but does not have to be compromised by documentation.

Recommendation: Plan ahead and engage key professionals and agencies in discussion regarding documentation so that when a disaster occurs, protocol and procedures are already in place.

Issue #7: Channeling Appropriate Research

Discussion: Following the Oklahoma City bombing, mental health professionals from across the country wanted to conduct research on the victims. The Governor wisely cautioned victims about participation in research studies. The Oklahoma State Health Department developed a registry of victims so that we could appropriately follow what occurred. Additionally, Okla-

homa channeled all potential studies through the University of Oklahoma Health Sciences Center Institutional Review Board. This protected victims and monitored the types of studies being conducted.

Recommendation: Utilize state agencies and resources to develop registries of victims when appropriate. Use Institutional Review Boards to assure protection of victims and to monitor the number and types of studies to be performed. Research protocols and procedures must take into consideration the context in which the incident occurs. Research protocols should include mechanisms for clinical referral of participants as needed.

Issue #8: The Human Element

Discussion: There are hundreds of disaster plans that give close attention and detail to the rescue and recovery effort. It is equally important to address the human side to safety, both physically and mentally. Once physical safety has been secured, address the emotional needs at every level of the community.

Recommendation: Provide a thorough plan for addressing all needs of the community with regard to the disaster. Recognize the level of complexity of the disaster and pay special attention to the unique issues associated with terrorism. Realize that as more events occur, they exacerbate the anxiety in victims of past events.

## Jack Poe

### Chaplain, Oklahoma City Police Department

At the time of the bombing, Chaplain Poe was home getting ready to attend a funeral. Around 9 miles from the site, he felt and heard the explosion. He turned on his police radio in time to hear a request for all officers to report to the scene of the AP Murrah Building explosion. When he arrived at the site, he began diverting traffic to allow room for emergency vehicles. He then called the FBI Chaplain to coordinate efforts for clergy at the scene. All the while, he found himself tending to people looking for their children and family members, trying to keep them calm and offer comfort.

When he was finally able to report to his command post, he began coordinating with Dr. Robert Allan, who had been assigned by Mayor Norick as head of clergy for the operation. Poe's wife began registering clergy and he and Dr. Allan began assigning them to triage areas, the temporary morgue and the Family Assistance Center.

Lessons Learned:

Issue #1: Chain of Command

Discussion: Civilian and military clergy need to coordinate a chain of command and develop an orderly, sensible way to credential and register clergy volunteers. Military clergy and their chain of command need to identify and work together with civilian clergy for the good of the cause. Military have their own protocol that they have to use as Standard Operating Procedure. There were major struggles between the Medical Examiner's office and the military regarding notifying family members. During the initial phases of the bombing, the military took charge, which resulted in clergy being excluded. When FEMA arrived they realized they did not have all the answers. The Chief of Chaplains in Washington DC, ordered local chaplains to bring in the team of chaplains from San Antonio. This did not occur because a military colonel said "No." This decision eventually led to a congressional inquiry.

Recommendation: As best one can, establish the chain of command between multi-levels of agencies. Determine who will be in charge of what during a disaster. Align all the players so that everyone knows ahead of time who is in charge of what.

Issue #2: Established Roles

Discussion: One expert clergyman, trained specifically for a disaster like the one in Oklahoma, was in Texas and was not utilized in the bombing. Not only did it hurt him by disenfranchising him, it hurt the process by not utilizing his experience.

Recommendation: Bring in experts to do an expert's job.

Discussion: Do not mix family chaplains with site chaplains. Family chaplains need to stay with families, and site chaplains need to stay at the site. They cannot float back and forth. The site chaplains have experienced too much that should never be shared with family. Family chaplains should never have to experience the site. They need to be strong for family members. Most family chaplains are not trained to endure those types of experiences at the site. Further, the site is a biohazardous area often requiring specialized training.

Recommendation: Determine which chaplains are to stay with families and which are to work the site and rotate shifts accordingly.

Discussion: The longer an incident lasts, the larger the turf issues become.

Recommendation: Align the players ahead of time to avoid huge turf battles.

Issue #3: Identification

Discussion: At first the FBI was processing ID's for everyone and was unwilling to relinquish control. They finally turned the process over to OCPD because the process was chaotic and was causing major issues. Over 28,000 ID's were issued.

Recommendation: The overall ID process should be unified and controlled by one entity. Clergy identification should be unified and established prior to an event.

Issue #4: Family Assistance Center

Discussion: There was not an appropriate plan in place for a Family Assistance Center. Initially, the Medical Examiner's Office set up the FAC and was using funeral directors to greet family members. This was extremely upsetting to family members who were not ready to accept the loss of a loved one. Clergy should have been available to counsel family members. Mental health professionals are also important to the process, but there needs to be an established team. Everyone grieves differently, so all the different players need to work together to offer a team approach providing family members with choices.

Recommendation: Identify the importance of a FAC in a city-wide disaster plan. Include all the players (clergy, mental health, etc.) and offer a case manager. Even though clergy are not therapists, they are therapeutic. All the players need to predetermine who is in charge of what at the FAC. It is also important to note that death notifications do not have to occur at a Family Assistance Center. Mobile teams should be available to go to families homes. Include a team of mental health, clergy, and others.

Issue #5: Spontaneous Volunteers

Discussion: Clergy from all over showed up to the site. First, there was no way to properly check on credentials. Second, it was difficult to register clergy and get a handle on processing and assigning. Too many volunteers at once create more work, more chaos and less ability to appropriately assign volunteers.

Recommendation: If possible, find a central source to educate clergy ahead of time to call first and not just show up.

Issue #6: Stress Debriefing

Discussion: Debriefing for OCPD began immediately. Many officers refused debriefing. Problems within the force started appearing later. Divorce rates are higher. Gambling, alcoholism, and other obsessive behaviors have developed within the force. In retrospect, the OCPD wishes they had allowed time between the incident and debriefing so that officers would have time to reflect and think about the event.

Recommendation: Allow time between an incident and the time you defuse/debrief. OCPD started debriefing too early and people hadn't had the appropriate time to reflect and think about the ordeal. Debriefing should be offered but not mandatory. No two people are the same. Families of officers should be included in the debriefing process. The most successful debriefing should be done one on one. Establish a plan for long-term mental health needs. "If you can't mention it, you can't manage it."

Issue #7: Training

Discussion: Allow clergy to "experience" the actual site before sending in clergy to talk to rescuers. Rescuers will not respond to anyone who hasn't experienced the same trauma. Always watch and evaluate procedures of clergy. If someone is violating procedure, remove them.

Recommendation: Properly train personnel prior to an incident.

Issue #8: Mandatory Shifts

Discussion: Several visiting volunteer police departments arrived at the scene and rotated into work. This caused friction and morale problems in the local police department. Additionally, some police officers and clergy members were working back-to-back shifts. This can quickly overstress staff.

Recommendation: It is important to control the number of hours worked, especially number of hours worked on the site. This avoids overstressing your clergy (eight-hour shifts should be the maximum to avoid emotional overload). Plans should call for mandatory rotations to include any and all local law enforcement first. Visiting volunteer officers can rotate in on a percentage of total law enforcement personnel needed.

## Cynthia Reid

### Marketing and Communications, Oklahoma City Chamber of Commerce (OCCC)

Cynthia was on the first floor of the Chamber building, three blocks south of the Murrah Building. Like most people, when the bomb exploded, she tried to identify what had happened. Most of her staff were attending a conference, so those remaining tried to determine where their co-workers were. One of her staff had a nine-month-old child in the Federal Day Care Center at the Murrah Building. She later learned the child sustained some injuries, but was going to be okay.

The Chamber controller and president decided to evacuate the building and sent staff home. Cynthia found herself sitting in front of the television all day and calling friends and co-workers. Since there was no crisis plan in place for the Chamber, Cynthia talked with her boss and started planning the next

day's events. Her role became that of the coordinator of the Media Center for all state and national media coming to Oklahoma City. She and her staff began assembling key information about the City for the media. They also staffed phones for the hundreds of calls coming in from all over the world wanting information on Oklahoma City.

Cynthia and her staff took a proactive approach and started tracking every call to the Chamber requesting media info. They built a database of each contact and their respective company. She did this because she knew some day she would want to invite them back for a positive spin on Oklahoma City. "Most people still had an image in their mind of Oklahoma City as a place where we live in teepees and ride horses," said Reid. Naturally, the first order of business as a city was to take care of the victims and their families, but as a Chamber, there was a need to focus on the Chamber's mission, which was to take care of the City's image.

Lessons Learned:

Issue #1: Planning and Training

Discussion: How can you respond when you are not even in your office? Chamber staff were sent home. Many could have maintained their synergy and been productive.

Recommendation: Every Chamber of Commerce should have a disaster plan in place. It should be practiced on a regular basis. Every staff member should have a role, know their role, and understand it explicitly. At a minimum, a plan should have called for them to forward their phones to their homes.

Issue #2: Contacts and Resources

Discussion: During the days after the bombing, Chamber staff was scurrying to put together packets of information regarding Oklahoma City for national and international media personnel. This took time away from other important things needing to be done.

Recommendation: Always keep background information current. Make sure your basic PR tools are in kits and ready to go. Have a network of public information officers and key contacts from community agencies already in a database and ready to distribute.

Issue #3: Mission

Discussion: In times of tragedy, focus on your mission. A Chamber's mission is to maintain the city’s image. Staying out of the way and allowing first responders and key personnel to do their job is appropriate.

The bombing galvanized Oklahoma City's plan to move forward. Rather than becoming the city everyone pitied, city leaders wanted the world to know Oklahoma City is a strong city doing great things. Even though the bombing slowed down forward plans, image was more important than ever.

The first year anniversary of the bombing was a key opportunity, yet the city needed to be very careful how it was handled. A committee was established with members from the families, victims and survivors to plan the day in a meaningful way. The city was still very raw and had not healed. Very little rebuilding had occurred, so there was a need to put a positive spin on a bad situation and not be viewed as a suffering community. So we highlighted the progress thus far and handed those stories to the media, e.g., small businesses that had moved back into their buildings.

It is important to note that in many ways, we are only recently able to really tell our story.

Recommendation: Be proactive. Spearhead the media so they don't drive you. Focus on your mission and stick to it.

Issue #4: Stress Debriefing

Recommendation: Consider offering stress debriefing to all staff.

Issue #5: Balancing a disaster with day-to-day duties

Discussion: Do not try to do too much. In addition to our response to the disaster, we still had our everyday duties to tend to.

Recommendation: It is important to maintain your routine and maintain the day-to-day tasks, while tending to a disaster.

## Bob Ricks

### FBI Special Agent In Charge

On April 19, 1995, Special Agent Ricks was in Shawnee, Oklahoma, participating in a golf tournament for Special Olympics. At 9:02 a.m., his pager went off indicating a major incident in downtown Oklahoma City. He headed for the site. Because of his background with the counter terrorism efforts in the FBI, his first thought was that a pipe bomb had exploded, or something small in scope had occurred.

He arrived in Oklahoma City at approximately 9:35 a.m. and remembers hearing an officer saying this was a massive incident. He then recalled the Waco, Texas event one year prior. SAC Ricks had been in Waco for the full 51-day standoff with the Branch Davidians. He suspected this incident had something to do with that anniversary. Coupled with the date, there had been a white supremacists incident alert through the FBI.

When Special Agent Ricks arrived on the scene, the police department had already barricaded the area, and one of the police captains waved him through. He went straight to the crime scene and met with Fire Chief Marrs and Police Chief Gonzales to determine roles of each and priorities of each. The FBI was in charge of the crime scene and the police would assist with security as well as perimeter control. The three agreed recovery efforts came first, but the Fire Chief and his staff did everything possible to cooperate with the FBI to control the crime scene and not jeopardize those efforts. They assured the FBI that as firefighters carried out search and rescue operations they would preserve materials for the criminal investigation.

The FBI created a field office near the site and set up a system for clearance to the crime scene including identification and registration. In addition, two general briefing areas were established, and all law enforcement agencies were invited to participate. There was central command, as well as an area for leads and an area to assign those leads to agents.

Lessons Learned:

Issue #1: Communication Among Agencies

Discussion: In Waco, SAC Ricks saw firsthand the damage in the relationships between local law enforcement and the FBI. He was determined this would not be the case in Oklahoma City. No one would walk away from the incident feeling alienated. Everyone needed to feel ownership and pride. Further, if everyone was empowered, communication would be enhanced and more leads shared, ultimately saving time in solving the case.

Recommendation: Offer daily briefings to the police and fire departments. Share as much information possible to create trust and open communication lines. Make the mission to get the perpetrator everyone's focus.

Discussion: The ability to communicate during the bombing was non-existent. Cell phones were overloaded, and radio systems were not compatible. Responders had to rely on runners, and this caused too much delay in getting important information early in the incident. Had responders had common frequencies on which to talk, some confusion could have been avoided. The problem was corrected by the second or third day, but that first day is critical.

Recommendation: Make provisions in the disaster plan for a solid and dependable communications system.

Issue #2: Resources

Discussion: The state of Oklahoma only had 115 agents, which was not enough to cover this case.

Recommendation: Utilize your resources wisely. Regardless of their disciplines, empower your most skilled to assume leadership positions in the investigation. It is still a criminal investigation, and you want your best investigators to be in charge.

Issue #3: Chain of Command

Discussion: It is important to allow local federal representatives to run the operation. The FBI typically brings in someone from the outside. This can cause major problems because the local representative has already established the essential relationships. Every major metropolitan area should have an established strategic plan, and everyone should know prior to an event what their role is.

Recommendation: Local FBI officials and the local responders should establish command and control over the incident. The additional federal resources should be utilized to supplement the local effort.

Discussion: Recognize that everyone wants to help. However, the information the FBI works with is classified and has to be treated as such. There must be a system to blend local law enforcement with the federal government. There has to be one central point to receive and analyze information. The FBI in Oklahoma City tried to include all local law enforcement as much as possible, but it became complicated because there was more than just the Oklahoma City Police Department involved. Multiple police departments, state police, secret service, DEA, etc., were all involved and wanted to be informed and helpful.

Recommendation: It is important to recognize and establish one central source for all law enforcement to work through and ensure that local law enforcement has a constructive role to play in the investigation.

Discussion: It is important to control the risk of any independent investigations. Sometimes other agencies want to be the hero and work independently. Sometimes you have to pull people back who are following their own leads. In a terrorist attack case, there are so many facets of classified information that have to remain classified. If agencies are conducting their own leads without proper coordination, this could jeopardize the successful outcome of the investigation.

Recommendation: It is imperative to have a lead investigative agency directing the investigation based on intelligence they have, but the effort must be coordinated with others involved. Allow the FBI to do their job and respect the need for controlled and classified information.

Issue #4: Leaks

Discussion: Leaks are always going to be a problem whenever sensitive information is shared with others. Politics are always a factor so just do the best job you can to contain those leaks. Information should be handled on a need-to-know basis.

Recommendation: It is part of the equation that stories and facts of the case will be distorted. Stay focused.

Issue #5: Staff Shifts

Discussion: Pace yourself and your staff with established shifts. Send half your officers home. Adrenaline kicks in, but that will only take care of you for about three days.

Recommendation: Establish twelve-hour shifts early in the process and stick to them. Take care of staff and self for the long haul.

Issue #6: Stress Debriefing

Discussion: An incident like the Oklahoma City bombing takes its toll on everyone. Recognize the need to address the incident and talk about it. If it can't be mentioned, it can't be managed.

Recommendation: Stress debriefing should have been mandatory. Recognize that everyone is different. Everyone heals differently. Participate and lend support to your staff.

## Anna-Faye Rose

### Director of Scholarship Programs and Survivor's Education Fund
### Oklahoma City Community Foundation

Anna-Faye Rose was named Director of Scholarship Programs and Survivor's Education Fund at the Oklahoma City Community Foundation in November 1995. Her position was originally intended to be an advocate to the needs assessment of the children of victims killed in the blast. However the scope of her job became much greater, including regular consultations with three contracted case managers.

It has been pointed out time and again by nearly every participant that their are challenges and blessings associated with the outpouring of donations. The blessings are obvious, the challenges complex. Several agencies in Oklahoma City collectively received over $40 million dollars in donations to assist the victims from the disaster. Most of the agencies biggest challenges were how and where to allocate the money. Initially, as money was pouring in, the Governor's Fund and Mayor's Fund were used to provide victim assistance for living expenses, counseling, funeral expenses, medical, housing, etc. Because everyone felt it was important to secure the children's futures,

keep them engaged in a successful path in life, and help them fulfill dreams, the Governor designated a major portion of funds be used for long-term needs of the children. Once a defined program and guidelines were established, the funds were designated for college scholarships for these children. Although this process took four months, it was a necessary step to secure a well thought out plan of action for everyone involved.

At the suggestion of FEMA and as part of their transition plan to leave Oklahoma City, an unmet needs committee was formed and called the Resource Coordination Committee. This committee, comprised of over 50 agencies in Oklahoma City that offered monies or services, met on a regular basis to hear needs and distribute funds and services to victims.

In June of 1995, Community Foundation contracted three case managers to work with children, families and individuals. Those case managers, along with others from surrounding churches and organizations, presented information to the RCC for discussion. In many cases, if a need was greater than any single resource, several agencies would pull together to take care of the need.

Lessons Learned:

Issue #1: The Unmet Needs Committee

Discussion: FEMA was only available for 90 days after the bombing to offer emergency assistance to individuals needing assistance for living expenses, medical, travel, etc.

Recommendations: As part of FEMA's transition plan, the City formed an Unmet Needs Committee, later referred to as the Resource Coordinating Committee (RCC). This committee's sole purpose was to take care of needs not otherwise handled by another source. Chaired by an impartial individual, the RCC met weekly for a three-year period to coordinate finances and services to victims of the bombing. The committee was comprised of approximately 50 agencies, churches, and volunteer organizations that had money or manpower they could offer victims. As needs were met and resources ran out, the committee dwindled to a few organizations. The RCC was extremely flexible and offered a diverse group of people and resources.

Issue #2: Established Relationships

Discussion: The community needed a central clearinghouse to manage and allocate funds for victims from the bombing. In order for the allocation process to work effectively, the community needed to embrace someone they could trust to appropriately develop a plan for allocating monies and a means

to do it in a timely fashion. Established relationships with key players in the community set a natural stage for OCCF to manage and allocate money with everyone's blessing already established.

Recommendation: In a disaster plan, designate an organization everyone trusts to manage funds and appropriate them according to a fair and just policy.

Issue #3: Preparing for Return to a Productive Life

Discussion: Recognize the importance of assigning a caseworker to families so that a continuum of care is achieved.

Recommendation: Divide the total number of individuals or families needing assistance by a manageable case load and set aside funds to cover the cost of a case manager for those cases. Assigning one caseworker streamlines work and processes for everyone.

Discussion: When offering assistance, it is important to be aware of families or individuals who become dependant on assistance. For some victims, it becomes a habit to continuously receive funding assistance.

Recommendation: Develop a plan to wean families off of assistance gradually. Recognize the areas where assistance can be gradually diminished and instill programs to help families get back to a productive life. In June 1995, OCCF hired three caseworkers to work with the 168 families, the 83 hospitalized victims, and the mental health needs of the search and rescue workers. Only nine families declined assistance. The caseworkers would contact each family each month to assess needs. By June 1996, OCCF case managers ceased monthly calls as the first step in assisting families to take the initiative to stand on their own feet.

By June 1997, OCCF only offered assistance to those in treatment or retraining. The methodology was to allow families to take care of themselves and establish self-esteem. By the third anniversary, OCCF required most victims to apply for disability.

(Each anniversary becomes a measurement for growth or progress and is the indicator for individuals to get help if they aren't progressing.)

- The McVeigh trial caused major slow down in many individuals progress.
- The May 3 tornadoes peaked mental health needs for rescuers.
- By the September 11 events, most survivors of the Oklahoma City bombing could distance themselves from those events.

Discussion: The number of patients requiring long-term needs is significantly less, but the financial responsibility is significantly more. Examples include:

- A lung transplant for a victim who sustained major trauma to his lungs.
- Hip/knee or other joint replacements that require updates.
- Mouth structures relating to tension

Recommendation: Designate funds for those needs and set policies in place to appropriately distribute funds, as they are available.

Issue #4: Mental Health

Discussion: To manage the mental health needs of the community in response to the bombing, FEMA set up Project Heartland through the Oklahoma State Department of Mental Health.

Recommendation: Most of the long-term needs included mental health issues. Oklahoma City Community Foundation utilized Project Heartland as a starting point for anyone needing mental health assistance. After an individual checked in through Project Heartland, they could access the Community Foundation for further counseling needs.

Discussion: Several victims from the bombing experienced periods where they did not seem to move forward in their therapy. Signs of improvement were not evidenced. The Community Foundation caseworkers were able to gauge the progress of patients and identify two concerns: the client stuck in anger and the therapist stuck in fear of the anger; and the client stuck in sadness and the therapist stuck in sympathy.

Recommendations: In the process of tending to mental health needs, it is important to obtain second opinions after a two-year period. This allows both the patient and the therapist an opportunity to reevaluate the situation, and it moves everyone forward.

Discussion: The Oklahoma City bombing proved to be a major catalyst to changing the way our culture views mental health. Prior to the bombing, some viewed counseling as a precursor to losing a possible promotion. This thinking resulted in a system of funding mental health services for Oklahoma City search and rescue workers that focused on anonymity. Nearly seven years after the bombing, approximately 50% of the Oklahoma City Fire Department's firefighters have received counseling and it is anticipated that the other half will access services in the future. Whereas the Oklahoma City search and rescue staff had to be brought into the mental health arena through the use of Crisis Intervention Workshops and strong advocacy by departmental chaplains, the Oklahoma City Community Foundation believes

that mental health services are an important step in sustaining a fulfilling career in search and rescue and that utilization of mental health services should be the normative standard.

Recommendation: Be proactive in your plans and approach to short and long-term counseling needs following a disaster. Offer incentives to those entering counseling soon after a disaster. Since no two individuals are alike, leave every option available for a case-by-case process and identify a local agency that can provide case managers to assist those with long-term needs.

Issue #5: Database

Discussion: The initial database developed for Oklahoma City, known as the Community Network Database, was donated by several organizations. IBM donated the equipment, and Lotus donated the software and programmers. The Database included information on the following:

- Victims and family registry including information on how the victim was affected and each family member.
- Needs and services from agencies and organizations available to victims and family members.
- A listing of the disaster funds available and a contact.
- A list of contributions disbursed by individual funds and category of need.

Each independent agency's case manager could check the database to confirm whether their client had already received support from another agency.

Recommendation: The system provided two important functions. One was to avoid duplication of services to individuals requiring assistance from several agencies and the other was that of advocate for families. An adequate database provides a unified approach to finding assistance for family members.

FACTS:

- 592 victims with injuries received assistance from the OCCF Fund.
- 83 Hospitalized victims received assistance.
- 509 outpatients.

Seventy families continue to be assisted on a regular basis by OCCF. The criteria for assistance fall into three categories:

- Those injured and needing continuing physical care.
- Those requiring mental health not covered under workers compensation (State workers were not, federal workers were insured).

- Families who have care of adopted children of parents lost in the bombing.

## Dr. Guy Sconzo

### Assistant Superintendent, Oklahoma City Public Schools

Dr. Sconzo had attended the Mayor's breakfast and had just returned to his office when he heard and felt the explosion. His immediate response was to get in his car and drive toward the site, assuming it was Emerson Alternative School. As he got closer to the school, he noticed a lot of glass and debris and injured students, but the plume of smoke was still further ahead. The alternative school, which included a program for pregnant teens and their babies, had sustained an extensive amount of damage. He attended to the needs of the school and tried to maintain calm and an order and line up buses to get the students and their infants out of the school.

The Oklahoma City Public Schools encompass 90 campuses and over 40,000 children. There are 6,000 employees and 80% of the school's population is from underprivileged homes.

At the time of the bombing, the Oklahoma City Public Schools only had single entity disaster plan. There had been no planning for all schools responding to a single disaster. It had never occurred to the district that they might have to care for all of their children throughout the district at the same time. As the disaster developed the school system struggled to create a plan.

Dr. Sconzo's first response after leaving Emerson was to drive to each of the other schools within a short distance of the bombing. Two of the three he visited had sustained damage. All 90 schools were impacted emotionally.

The immediate focus was to keep the schools in session and create as much normalcy as possible. Many parents were arriving at the schools wanting to pick up their children, but the schools remained opened for those children who needed to stay. Dr. Sconzo's staff wanted to keep order at the schools to help minimize the chaos downtown.

The major challenge was the simultaneous lack of communication between all the schools. We had to send administrators out to each of the schools and communicate via cell phones, even though most cell phones were not working the first day.

By the second day, Sconzo and his staff were conducting assessments with each principal to ascertain the individual needs at each school.

With no disaster plan in place, the process of trying to release children who had lost parents in the bombing was haphazard at best. Most children directly affected were picked up by family or neighbors.

Lessons Learned:

Issue #1: Planning and Preparedness

Discussion: Take the time to organize instead of reacting to a disaster. Sconzo jumped in his car and headed to all the schools near the scene instead of consulting with staff and setting forth a plan for the day. People at all levels were relying on his guidance and he reacted instead of orchestrating and coordinating. An established and practiced plan would have helped him instinctually to pull together resources within the system and implement the plan.

Recommendation: Have a district-wide disaster plan for a major incident. Make certain your plan includes the release of students, the appropriate steps to take and defined roles. Have a backup plan for teachers who may be affected directly. Be involved with a city-wide plan. Educate and train your staff the best you can for any crisis and crisis counseling.

Issue #2: Communication

Discussion: Communication is extremely important and not having appropriate communication led to more stress, anxiety and chaos. On the day of the bombing, there was no way to communicate between schools. Officials had to get in cars and drive from school to school to communicate.

Recommendation: Plan for appropriate communication needs such as two-way radios. It is critical to have organized effective communication between schools and administration.

Issue #3: Human Element

Discussion: The Los Angeles Unified School District came to Oklahoma City to walk staff through the steps to take in the aftermath. This was a major saving grace.

Recommendation: Use all qualified resources to take care of people, including staff, students, and families.

Issue #4: Mental Health

Discussion: In the aftermath of the bombing, the Oklahoma City Public Schools received thousands of calls from mental health professionals wanting to help. It was overwhelming, and there was no way to appropriately utilize all the services in an organized fashion. Through FEMA, the OCPS received a $1.4M grant for 18 months of counseling, but it wasn't enough and the grant had to be extended.

Recommendation: Recognize the magnitude of the mental health toll. Pace yourself and your staff and stay focused on your own needs while focusing on everyone else's needs. Plan for mental health. Allow staff the time to grieve. That year was never normal after April 19th.

Issue #5: Media

Discussion: On April 19, 1995, the Oklahoma City Public School system was responsible for over 40,000 students. It never occurred to administrators to try to utilize the media to communicate to parents. If the public schools had aligned themselves prior to April 19th, the media could have reported to parents regarding their children's safety and related issues.

Recommendation: Work with your media prior to an event and establish their role as a conduit for communication to parents. Educate parents that this is how they will receive information in the event of a disaster.

Issue #6: Established Relationships

Discussion: Many of the teachers were displaced after the bombing because their apartments were destroyed by the blast. Resources needed to be lined up to take their place until their needs were handled. If the school system had better connected itself with the fire department, police department, media and others prior to April 19th, this issue could have been addressed. It wasn't until two years later that administrators were able to sit around the same table with all the parties involved.

Recommendation: Align your resources ahead of time so that when you need them they are already there. Get to know other agencies and define roles so that you can aid each other.

## Ken Thompson

### Family Member

At the time of the bombing, Ken was six miles away at a credit union where he worked as Vice President. His mother worked in the Federal Credit Union located in the Alfred P. Murrah Federal Building. When the blast occurred at 9:02 a.m., he first identified what had happened and then tried to locate family. He immediately called his brother to help locate his mother. He then spent five hours at St. Anthony's trying to identify his mother as one of the survivors. From there he went to the church on 14th Street and dropped off material to identify his mother. Later he was told by the media to go to the established Family Assistance Center at the First Christian Church. He and his family went back to the church on 14th Street, picked up his mother's material and then took it to the FAC at the First Christian Church where he spent the next 17 days.

Key Components to the Family Assistance Center identified by Ken include:

- Mental health professionals made available by the Red Cross to counsel, etc.
- Funeral Directors
- Cellular telephone service to make calls
- Clergy supplied by the Salvation Army
- Hot meals and food
- Regular reports from the Medical Examiners Office each day at 10 a.m. and 3 p.m.
- Visible banners and well wishes from all over the world
- The ability to socialize with famous people who wanted to stop by and do something nice for them
- A library of inspirational materials to read and reflect on during the days

The FAC gave the family members an opportunity to be with each other in a private setting, screened from the media. However, they had the choice to speak with the media if they so desired. They also had the option of bringing in their own clergy members.

One part of the FAC Ken considered vital was the Medical Examiner's daily visits, and his honesty even to the point of hurting. Ken and other family members always knew someone would level with them and provide the truth of what was taking place at the site.

After 17 days of search and rescue, there were two identified victims still in the building that rescuers could not recover due to safety hazards. Ken's mother was one of the bodies. He and his family were provided the opportunity to go directly to the site, say good-byes, offer last rites and have a memorial service. Ken said this was critical to their healing process even though it was very difficult. He recalled how the rescuers located and identified the area where his mother would most likely be found. They laid a tarp over the area to protect her body and the area and then, after the building was imploded, they were able to recover her body.

FAMILY ASSISTANCE CENTER GLITCHES:

- At first there was no flow. Families were going to St. Anthony's and then to various churches as directed by the media.
- There was an issue with the family members being adequately identified, so a tagging system had to be developed.
- In retrospect, media should have been kept at a further distance.
- Families needed a place to lie down and rest and the Oklahoma City FAC offered no such facilities.

Ken said as a family member he was not aware of any behind the scene problems but later learned there were several issues regarding what and when to tell family members. These issues were mainly between the medical examiner and the incident commander, Fire Chief Marrs.

Constructive Insight for counterparts:

- Trust instinct in taking care of families. Make certain the FAC is a caring place for families. If you have doubt, don't do it.
- Offer childcare. It gives kids a healthy avenue for play with mental health professionals who understand the children's needs and provides parents time away from kids to deal with their emotions.
- Family members of victims of disasters need to be able to get involved and help. It is important to get involved early and carry out appropriate training so that when an event occurs, you are in the system and can be processed and placed to help. The best contact is your local Red Cross.

Ken said volunteers and people who come to help make a difference. After six years, he is still a changed person largely due to the fact that so many caring people came to hold his hand and be there for him in his time of need. That made the difference.

## Charles van Rysselberge

### President, Greater Oklahoma City Chamber of Commerce

April 19, 1995 fell three days before the City's annual founding celebration, the Land Run of April 22, 1889. At the moment of the explosion, Charles was four blocks away on the fourth floor of the Chamber building. Within 15 minutes, he attempted to go to the bombsite and was turned away by police within one block of the bombed building. His offices were evacuated due to possible gas leaks, so he spent the day in a temporary office at the Oklahoma Publishing Company.

That evening was spent on the phone with staff, volunteers and a consultant the Chamber had hired weeks prior to map out a public relations plan for the city. Two major efforts were identified for the Chamber: an emergency business assistance center and a news media center. Charles received approval from the general manager of the Medallion Hotel to utilize its lobby for the news media center, which became a hotel room locator service for news media coming into the city from around the world. Then he called Southwestern Bell to arrange for eight phone lines to be installed in the boardroom for the business assistance center. The State Chamber agreed to provide a Business Relief Fund if the City Chamber would provide information on the needs of businesses most affected from physical damage.

Lessons Learned:

Issue #1: Preparedness, Planning, and Training

Discussion: At the time of the Oklahoma City bombing, the Greater Oklahoma City Chamber of Commerce did not have a crisis management plan in place. Because there was no plan, none of the staff had a clear understanding of their role during the day of the bombing, which went into implementation the next day. Everyone was sent home and waited while Chamber officials developed a strategy and an overall plan of action. The Chamber President's first priority was to tend to community business needs and news media.

Recommendation: A well thought out disaster plan created and practiced prior to April 19, 1995, would have saved time and energy. It would have provided direction for other Chamber employees and included them in the process during a chaotic time.

Issue #2: Stress Debriefing

Discussion: Several staff members experienced depression in the months following the bombing. Many lacked focus on the job and in their personal lives. The Chamber also recognized a higher level of turnover in the first years following the bombing.

Recommendation: Stress debriefing should have been made available to staff so they could have talked through and channeled their emotions and feelings.

Issue #3: Media

Discussion: The city had not anticipated over 2,000 news media personnel from around the world visiting Oklahoma City within a four-week period. Until this event, there had not been a central information center within the city for a media event of this size. Each morning began at 5:00 a.m. serving coffee and doughnuts. Chamber staff also distributed media kits with background information on Oklahoma City. The Media Center was in operation for four weeks. Chamber staff distributed 800 news media kits and coordinated over 200 news interviews. Additionally, the Chamber staff set up the News Media Center at the State Fairgrounds on Sunday, April 23 for the memorial service attended by President Clinton.

Recommendations: A central information center for all organizations to channel media eliminates duplication and helps streamline a unified message for the city. A Chamber of Commerce can organize the resources so that concurrent media events can offer a unified message from the City.

Issue #4: Impact on Small Business

Discussion: Over 1,700 small businesses were in the four zip code areas of downtown. It was important to survey those businesses to determine how many were damaged and what their needs might be. Many of the businesses and citizens were not aware of their property insurance policies and did not understand their coverage. 45% had no insurance.

Recommendation: As part of a city-wide disaster plan, Chambers should develop a plan for and orchestrate services to the small business community. Managed by the Small Business and Economic Development Divisions of the Chamber, 50 volunteers sent out letters to 1,727 businesses in four zip code areas of downtown. In a four week period after the bombing, 3,540 calls were made, 1,098 businesses were okay, 240 businesses were damaged but okay, 102 businesses were damaged and needed help, and 287 businesses were not contacted. They had either gone out of business or previously moved. $240,000 was collected from local and national sources including other chambers, businesses, and the Salvation Army. In addition, over 130 companies offered in-kind services, furniture, equipment and temporary office space. Charles, the State Chamber President, and the local commander of the Salvation Army, served on the allocation committee. Over 80 businesses applied for financial support.

## Kari Watkins

### Executive Director, Oklahoma City National Memorial

Kari's involvement with the Memorial began in January 1996. By the time she was hired as the Memorial's first employee, the memorial process was underway with committees in place. Surveys had been sent to family members, survivors, rescue workers and City leaders to start formulating a mission statement.

She recognized Oklahoma City was setting precedent. It was important to keep volunteer leaders running the process and in the forefront. These leaders were individuals whom the community needed to identify with and give credit.

The mediator for the process was a local community volunteer that everyone respected. Kari considers the use of local volunteers to have been critical to the process. She remembers the best advice ever given to her was to keep the process local because the local community would live with the decisions forever. Additionally, no one would be invested in the cause like the local community.

There were times the process seemed to take longer simply because of the dynamic of the audience. Family members, survivors and rescuers all shared loss, guilt, grief and, while essential, it took time to sort through those feelings and emotions. The Oklahoma City National Memorial process

proved much more expedient than other national memorials. Part of the expedience was due to the leadership taking the time to study other memorial processes and adapting Oklahoma City's process accordingly.

Although some family members felt it was too soon to start the process, Kari believes it was essential to the healing and rebuilding of the community. For many, it offered a sense of hope and healing and a way for them to give back to a community that had given so much to them.

By the second anniversary, the Memorial task force was able to reflect and rebuild. They named five finalists and were ready to enter the design phase. At the time, Oklahoma City had staged the largest memorial design competition in the world.

Lessons Learned:

Issue #1: The Mission

Discussion: The first task was to establish the mission and characteristics of the Memorial. This was the most painful task but also the most rewarding. The mission is "what we want the Memorial to say." Its elements include strength, hope, serenity, peace, comfort, and the knowledge of the impact of violence. Above all, it includes remembrance. Then it was important to determine who was to be included (everyone), the message, how it impacted the audience, and how the Memorial should make people feel. The mission continues to guide those involved with the Memorial every day. It serves as the cornerstone document for every decision.

Recommendation: Never focus on what the Memorial should look like. Always focus on the message it should convey. If you focus on the design, you will never get there.

Issue #2: The Process

Discussion: Do not be afraid to use local resources. Those closest to the community understand best and have the most invested. It definitely will slow the process, but it will eliminate controversy and be the most sustainable. Above all, operate with an inclusive process. If people are included, they will be empowered to support the decisions. Never give anyone reason to say they were excluded.

Recommendation: Recognize the process is more important then the product. Commit to the fact that the process will be slow, but that is what is necessary to get to the end. The Memorial process changed the way Oklahoma City does everything. The inclusive process has become a standard way for the community to make decisions. The more people are included, the more sustainable the project and the more positive the outcome. Do not get caught up in policy and procedure. Institutionalization can come after the project

becomes larger then the individuals. Establish the key leadership in the process and set clear boundaries for those people. Strike the balance between leading the group and securing consensus.

Issue #3: The Human Element

Discussion: Do not be afraid of the emotion. There must be a delicate balance between the human process and moving ahead.

Recommendation: Include mental health professionals you can trust in the process. They will help control the flow and content and can identify those stuck in the process and help them move forward in a sensitive manner. Always put the volunteers at the forefront. Give them public recognition and a publicly unified voice. Keep people regularly informed. Agree to disagree and agree to compromise. Everyone has a voice and opinion. Allow those opinions to be shared. Find ways to incorporate participants in anniversaries, ceremonies, ground breaking, etc. (When Oklahoma City broke ground, every family member, survivor and rescue worker who wanted to take part helped move the fence.) Make yourself accessible for those who have an interest in participating.

Issue #4: Next Steps

Discussion: Financial accountability and education are important to the final outcome. The Oklahoma City National Memorial installed donor computers in the museum to show accountability for every penny given to the project. Outreach and education are important because they move the project forward.

Recommendation: Do not forget financial accountability and education in the planning. Once the physical structure is in place, look ahead and begin to develop a strategic plan for the project so that is becomes a living memorial.

Issue #5: Resources

Discussion: At the beginning of the Oklahoma City process, a design consultant was hired. The consultant refused to work with family members because they were "too emotional." The leadership fired him at the request of the family members. This was a pivotal point in the process because it galvanized the trust between the leadership and the family members and helped move the project forward.

Recommendation: Recognize the experts in the field, but don't be afraid to trust your own community. The community knows best what is right for it. The answers are all inside. As long as there is validity and trust in the process, the outcome will be successful. Always include the families, survivors and rescue workers. If they don't want to be involved, that it their

choice, but give them the option. Involve as many from the community as humanly possible. Through involvement, you empower, and, once empowered, there is little need for criticism.

The partnership formed with the National Parks and Recreation Services was a positive move. The Memorial gained the respect, high standards, and credibility as a National Park but was able to maintain a local voice for family members and survivors.

Issue #6: Anniversaries

Discussion: The anniversaries are critical to the process and the psyche. It is important to honor the date as a ritual for remembrance. It also helps to measure how far a community and individuals have come, while appreciating all that has been accomplished. It marks another passage on the journey.

Recommendation: Take the time to plan a meaningful anniversary. Recognize you can never close the door and learn how to incorporate the experience into everyday life. You can move forward and grieve at the same time. For most people, the recognition of the date is a positive step in helping move forward. Do not ever expect closure. There is no closure because there is always a story to tell.

Issue #7: Established Roles

Discussion: Securing a key person to lead the process was just as important as dividing the groups into committees and giving those committees set boundaries and direction to compete the individual tasks. Establish who needs to do what and then organize the process so that each of the individual committees can report to the entire group.

Recommendation: Establish the key leadership in the process and set clear boundaries for those people. Strike the balance between leading the group and securing consensus.

Issue #8: Recognition

Discussion: Recognizing names on a memorial is an arduous process.

Recommendation: Don't assume public records are accurate. Include all family members, spouses, in-laws, etc., in the process and take the time to get consensus. Set ground rules and deadlines and have the family sign off on the correct spelling. Have donors sign off on their listing at the time of the donation so that no changes occur after the fact.

## Terri Watkins
### Reporter, KOCO TV Channel 5

Terri Watkins' initial response was to get to the site and start reporting. She remembers finding a Channel 5 truck about two blocks from the building and setting up a satellite to begin reporting. She worked 24 consecutive hours the first day and averaged 17-hour days for the following weeks. For Terri Watkins, April 19, 1995 was just the beginning. Nearly seven years later, after covering the investigation, trial and execution of Timothy McVeigh, she continues to cover the trial of Terry Nichols.

Lessons Learned:

Issue #1: Planning and Preparedness

Discussion: Oklahoma City had trained several agencies within the responders' circle for disasters, but no one had trained in terrorist-type disasters. The media had never been included in any type of planning and still isn't. After the first 24 hours, processes were established and the chaos became manageable.

Recommendation: The best-laid plan will have to be altered. Every disaster is different, and therefore every response will be different. Coordinate as best you can and regularly update the plan and people involved.

Issue #2: Donations and Spontaneous Volunteers

Discussion: Volunteers and donations started showing up at the site almost instantly. Part of a disaster is the human spirit of people wanting to help. The key is to find a way to channel or funnel peoples' energy from needing to be at the scene and being part of the problem to staying at home and helping in other ways.

Recommendation: Recognize that you have to offer people an avenue to help. Work with the Red Cross or Salvation Army to create tasks for volunteers separate from the disaster zone.

Issue #3: Communications

Discussion: During a disaster there will be an initial period of chaos where no one can effectively communicate. Whether the plan calls for two-way radios, cell phones, or otherwise, effective communications will be impossible for a period of time.

Recommendation: Have a plan with a backup but recognize there is no effective solution for every disaster. Use common sense. Use the media to communicate with the public.

Issue #4: Reporting Injuries and Victims

Discussion: During the Oklahoma City bombing, every hospital had a different policy for reporting patients and injuries. Hospitals did their best to keep the media away, but reporters also did their best to inform their public.

Recommendation: If possible, hospitals within a city should work together to establish a unified reporting system and a mutually agreeable policy. People need to know if their loved ones are alive and where they are located. Cities need to work together to efficiently and expediently report lists of victims/patients.

Issue #5: Established Relationships

Discussion: Watkins knew the players involved in the recovery effort for years. They had an established sense of trust and knew how to deal with each other. If the fire, police, or other public information officer needed something, all they had to do was ask, and the media would take care of it. When the responders needed a place for a temporary morgue, they initially wanted to move the media and use the area the media was staged. Because of Terri's rapport with several of the public information officers, she was able to suggest moving the location of the morgue, as opposed to trying to move the media and keep them from seeing activity within the temporary morgue.

Recommendation: The value of networking among the responder community is immeasurable. It is important for the media to establish relationships with responders and establish ground rules. Responders need to understand the media's perspective and recognize the importance of the media's participation during a disaster.

Issue #6: The Human Element

Discussion: The local stations chose to continuously cover the recovery effort for 186 consecutive hours. After the prayer service on the Sunday following the bombing, the local television stations ended the non-stop coverage. The prayer service allowed everyone to take a step back and regroup. From that point on, the community was exposed to all of the news surrounding the trials and then the execution. There is no manual on when it is appropriate to move on and when it is not. Everyone has his or her own opinion.

Recommendation: At every level of the experience, it is appropriate to do what is best for your community. Make decisions based on what feels right and move on. Don't ignore the signals. Deal with the hard decisions and recognize there is never closure. Most media personnel never have to make the decision to "put the camera down to help or keep shooting?" If you are put in that position, then the reporter helps and the photographer keeps shooting.

## Richard Williams
### Survivor

Richard Williams was the Assistant Manager of the AP Murrah Federal Building. The morning of the bombing, he had arrived at work at about 6:15 a.m. and logged on to his computer to check up on those Federal buildings in the state for which he was responsible. His office was on the ground floor on the north side, and he was just feet away from ground zero where the truck bomb detonated. He has no memory of what happened.

He is still healing from the massive lacerations he sustained. But Richard Williams focuses on the positive changes in his life.

Location, accessibility, and the fact the Murrah Building had a glass front could be some of the reasons it was a vulnerable target. The Occupation Emergency Plan (OEP) saved lives. Everyone that worked in the building knew how to get out of the building thanks to practice and drills.

He returned to work after 43 days, although he was relocated to the downtown Medallion Hotel. He remembers one positive outcome from the bombing was the fact that the government recognized there was not time to go through standard operating procedure, so they cut the red tape, realizing some of the bureaucracy needed to go by the wayside.

Much of Richard's knowledge of the building became the blueprint for several blast studies conducted after the bombing. Much of that information became key evidence for the trial against Timothy McVeigh.

The Memorial Process

Early on, Richard was involved in the Memorial process, and, because of his job, he was instrumental in securing the warehouse to store much of what would later become the Museum archives. Initially, he was one of the few that did not want to tear the building down because it was so much a part of his life. Once the building was imploded, he became the protector of the "sacred ground." The GSA had repaired the parking structure, laid the sod and put the initial fence around the area. He didn't know at that time that the fence would become a powerful symbol of the memorial.

Richard held the key to the locks of the gates of the fence and was protective and respectful. He only allowed family members, survivors and rescue workers on that ground until the Memorial was completed.

One important lesson in the Memorial process was the decision to reach out not just to survivors, rescuers and family members but also others changed forever. As a founding Trust member, Richard chaired the Survivor Defini-

tion Committee and served on many other committees. His committee's task was an elimination and facilitation process. He made sure the committee was well represented by all constituents, including those who worked in those offices but were not there that day, and those who were planning to be there that day but were not for other reasons.

This process was difficult because hard lines had to be drawn regarding offices surrounding the buildings and where those lines started and ended. The committee finally had to reach a consensus and move forward, realizing they would not be able to include everyone.

Another important lesson was to recognize that closure does not exist and it is not necessary. People learn to cope, but the pain never ends. As the saying goes you do not "open old wounds…they just never close." You do not dwell on the bad, but you live it every day and acknowledge it. Everyone is in a different phase of the process. It is important to continue to embrace it and educate others in hopes to prevent.

Another lesson learned regards the bond that forms between families, survivors and rescue workers. Those closest understand each other and what they are going through. They all experienced something very tragic, but all want to find the good. There is a mutual respect and understanding that no one else can understand unless they have been through it. This "bond" is an important lesson for future events. Those who have been through something tragic can and should reach out to those experiencing it for the first time. Just as firemen and policemen require peer review in stress debriefing, the same applies to survivors and family members needing peer support. "They aren't therapists, but they are therapeutic."

Anniversaries will always be very important to the process.

Throughout the course of the memorial process, the participants always took two steps forward and three steps back to check, recheck, and check one last time on decisions that they made. This added credibility to the process and afforded everyone involved trust and respect.

Mental health proved to be another important lesson in the process. The GSA offered group counseling. It was counterproductive because everyone handles and copes differently and everyone had different experiences. It is important to not confront counseling needs into a cookie cutter approach. Richard waited three years to finally get counseling. It was much later and after he had focused on everything else first. Where you are emotionally prior to an incident will dictate where you are emotionally after one. Those who are not healthy will be worse, those who are initially healthy will be better.

It was important in the Memorial process to speak as one voice. Some tried, during the process, to speak for everyone. It was never fair to anyone to speak for everyone. You can only speak to the process, not to people.

Media were restricted on the Murrah site. Even at the dedication, media were kept behind the lines and only family members, survivors and rescuers were allowed on the site.

## Ted Wilson

### Chaplain, Oklahoma City Fire Department

April 19, 1995, Ted Wilson was on bereavement leave and was still asleep following a long day attending a family funeral the day before. The reverberation and noise from a large explosion awakened him, and he quickly learned the Alfred P. Murrah Federal Building had been bombed.

His first response was to go to the scene. He grabbed some gloves, went into the building and found his way to the Federal Credit Union where he found a woman pinned under a huge slab of concrete. He and several state troopers started an IV while attempting to free her by removing the slab. During her recovery, the building was evacuated because of a bomb scare. He and his crew chose to stay with her. He prayed with her, and eventually they were able to get her out of the building.

He left the scene after the first day and was assigned back to the site the following day as Chaplain. His main responsibility was to establish the debriefing area with the Critical Incident Stress Management Team (CISM). They ended up moving the CISM area five times before they finally settled at the Southwestern Bell Headquarters building.

Initially, it was mandated that every firefighter be debriefed upon leaving the scene. They realized they needed to modify that process when several of the firefighters became anxious about going to the site. Therefore, the CISM teams began briefing the firefighters before they entered the building on what to expect that day. Then as firefighters checked out, they would offer a quick assessment to the rescuers to make sure everyone was handling the situation.

At the CISM area, firefighters were offered food, phones, medicine, massage, chiropractors, dry clothing, vitamins, shots and anything they needed to assist them during the rescue and recovery efforts.

After 16 days, most firefighters were sick of the debriefings and some tried to skip them. However, it was imperative to allow them the opportunity to verbalize instead of internalize.

On the actual site, Chaplains would walk around and engage in conversation with the rescuers to do "pulse checks." Often times they would find firefighters inside the building crying. They would also find construction workers breaking down and would offer CISM to them, but none engaged. Wilson says they paid a price for those decisions.

In addition to helping the firefighters, the Chaplains set up debriefing sessions for the firefighters' families. Although only 1/3 of the firefighter families came, it was important to provide the firefighters' wives and children a place to ask questions and vent their frustrations and fears. Topics discussed included the safety of the building, the process of the search and rescue, signs to look for indicating posttraumatic stress syndrome and ways to get help.

Children were given a stuffed animal to "replace" their daddy while he was gone and then when daddy returned home, the animal could go on the shelf. A grief monkey was also brought in and the children were able to hug, hold and play with the monkey.

Lessons Learned:

Issue #1: Established Relationships

Discussion: It was extremely beneficial to already have had the relationships in place with other fire districts through training and working relationships. This enabled everyone to work in a unified fashion and be more effective. Everyone "needs" to be needed, so if you meet that need, you don't end up with jealousy and turf issues.

Recommendation: Establish relationships with other resources prior to an event. Utilize those resources and coordinate them for the good of the cause.

Issue #2: Stress Debriefing

Discussion: The fire department should have waited a minimum of 16 days before debriefing the rescuers. This would have allowed the rescuers time to desensitize and evaluate their own feelings. Had they waited to debrief the rescuers, the debriefing would have been more successful for each individual rescuer. Senior officers should have been debriefed separately. Their attitudes were negative towards the debriefings, and it was detrimental to the process. In retrospect, the Chaplains felt they should have done more for the families and should have sent letters directly to the spouses or phoned them to get a better turnout. They later learned that many of the firefighters reported to their wives that this wasn't important, so the family debriefings were not as well attended as they should have been.

Recommendation: Establish a well-rounded and thorough debriefing process for your department. Include every level and family members in the process. Ensure the plan addresses individual needs and incorporates a full continuum of care.

Issue #3: Long-term Mental Health Needs

Discussion: Prior to the April 19, 1995 incident, Oklahoma had very few mental health professionals who understood Posttraumatic Stress Disease or Critical Incident Stress Debriefing. This prolonged and confused care given to individuals requiring help.

Recommendation: Do whatever it takes to get administrative commitment to tend to the emotional response of the firefighters. Research and administer a multi-pronged approach to mental health that includes different types of treatment for different people. Know when to call for help and call experienced professionals. Be proactive with your employee assistance program. Operate within your system but expand it if needed. Develop a network of professionals. Set that in motion before an incident. Develop a solid core group of mental health professionals that you can educate and train to understand firefighters. Do this before an incident. Firefighters are a different breed. They don't readily talk about their "problems" so you have to understand the nature of the breed first. Offer in-services for the mental health professionals and educate them as to what firefighter needs are.

Have a plan for monies to be made readily available for mental health needs. Make sure there is no red tape and make sure that plan offers total anonymity and confidentiality for those who need it. Getting a firefighter to ask for help is monumental. Once they ask, don't make it impossible to get the help due to red tape and bureaucracy. If funds are lacking, the State should step up to the plate.

Establish a pre-plan, an on-site plan and an after-care plan for mental health. Be proactive and aggressive and make the after care easily accessible.

Issue #4: Spontaneous Volunteers

Discussion: An incident of any great size is burdensome in and of itself. Volunteers start pouring in from everywhere. It's important to allow those volunteers to work, but you need to have a resource in place to have someone available to "find the volunteers something to do."

Recommendation: Establish relationships throughout the district. Engage and educate other chiefs to find something for everyone to do so that, while you are tending to recovery, they can be taking care of volunteers.

Issue #5: Planning and Preparation

Discussion: The fact that our key players had gone to Emmitsburg, MA the year before was great, but information was not shared with all the appropriate people when they returned.

Recommendation: Offer training and ensure those who attend share the information with those who do not.

Issue #6: Communication

Discussion: Different agencies at different levels were using their own terminology. This created confusion among agencies and caused breakdown in communication.

Recommendation: Make certain all your people understand the many different acronyms. Terminology is critically important during and incident. Where possible, establish unified acronyms and terminology.

Issue #7: The Human Element

Discussion: Recognize that a disaster requires response and recovery, but the human emotion involved is every bit as important. It is human nature to want to be in control and to want to fix what has happened, but there has to be a chain of command and an order to the process.

Recommendation: Turf issues are going to happen. Where possible, keep it behind closed doors. If you make a promise, keep it. Work together with other agencies in the process to establish order prior to an event. Education is key.

Issue #8: Family Assistance Center

Discussion: As laid out in the "plan," the fire department began setting up the Family Assistance Center with the aid of the Red Cross at City Church. Simultaneously, the Medical Examiner's Office was setting up a Family Assistance Center at the First Church of Christ. The media was reporting that families should go to the First Christian Church location, and it was only when the fire department asked the media to report the families go to City Church that they realized a FAC was already established. This caused a great deal of confusion. Had both been communicating with each other, it could have streamlined the process. Additionally, as families entered the FAC, they were greeted by funeral directors wearing their name badges. Family members were not ready to accept that their loved one may be dead. In retrospect, if the funeral directors had worn generic name badges, it would have been more effective.

Recommendation: Establish a plan for a Family Assistance Center and include all the players in the planning process. (Mental health, clergy, Red Cross, fire department, Medical Examiner, etc.)

Issue #8: Established Roles

Discussion: Prior to an event, the fire departments should have a state network. Oklahoma City relied on local CISM teams and those people were already in the building rescuing people, so additional backup was needed.

Recommendation: Establish ahead of time who is responsible for what and then educate and train so people can be counted on to fulfill those roles.

Discussion: Make sure you share a common goal among the rescue community to first save lives and second, restore families. You can't return their loved one to them, but you can help restore their families.

Recommendation: As part of disaster training and education, this should be addressed.

Discussion: Use clergy for family and chaplains for the scene. Clergy are not equipped to handle disaster scenes, but they need to be there for families. They don't need to be traumatized.

Recommendation: As clergy volunteer their time and effort, recognize the difference between each task. Establish a process to credential and assign clergy and chaplains prior to an event.